PHYSICAL EXAMINATION

NAME OF CAMPER:____

IMMUNIZATION HISTORY – This is a record of dates of basic immunization and most recent booster doses.

DTaP, DTP, DT, Td	Date ________	Date ________	Date ________	Date ________	Date ________
Polio	Date ________	Date ________	Date ________	Date ________	Date ________
MMR	Date ________	Date ________	Date ________		
Hemophilus Influenzae type b (Hib)		Date ________	Date ________	Date ________	Date ________
Hepatitis B	Date ________	Date ________	Date ________	Date ________	
Varicella	Date ________	Date ________			
Pneumococcal Conjugate (PCV)	Date ________	Date ________	Date ________	Date ________	Date ________
Other ________	Date ________	Other ________	Date ________	Other ________	Date ________

MEDICAL EXAMINATION – To be filled out by licensed physician.

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

Code: S = Satisfactory
X = Not Satisfactory (Explain)
0 = Not Examined

General Appearance ____

Genitalia ____

Height ________ Weight ________ Blood Pressure ________ Posture & Spine________ Throat - Tonsils________

Nose________ Teeth________ Abdomen________ Hernia________ Feet________ Lungs________ Skin________

Hgb. Test (Date)________ Urinalysis (Date)________

Eyes________Vision ________w/Glasses ________ Extremities ________ Heart ________

Ears ________ Hearing ________

Neurological Findings ____

Describe Abnormal Findings and/or Handicapping Conditions ____

____

Allergy: *(Please specify)*____

Recommendations and restrictions while in camp:

Special Diet ____

Special Medicine (dose, route of administration, when should it be administered)________

Is parent/guardian sending special medicine?____

Activity Restrictions ____

Swimming ________________________ Diving ________________________

General Appraisal: ____

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____

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.

________________________ M.D.
EXAMINING PHYSICIAN (SIGNATURE)

____
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone ________________ Address________________________

Date of Examination ________________ ________________________
ZIP CODE

DCR 7 (Rev. 2/04)