

Today's date: \_\_\_\_\_, 2012

### Summer Camp Medical Form

Name of camper: \_\_\_\_\_ M\_\_\_ F\_\_\_ Birthdate: \_\_\_\_\_  
mo/day/yr

Home address: \_\_\_\_\_  
Street City Zip

Parent/Guardian: \_\_\_\_\_ Telephone number (\_\_\_\_\_) \_\_\_\_\_

**Medical examination: (completed by licensed physician)**      **Date exam performed:** \_\_\_\_\_

Does this individual have a cognitive or other disability? \_\_\_\_ Yes \_\_\_\_ No

What is the specific cognitive or other disability? (Check as many as apply):

Autism \_\_\_\_ Down syndrome \_\_\_\_ Orthopedic disability \_\_\_\_ Blind \_\_\_\_ Deaf \_\_\_\_  
 Mental retardation \_\_\_\_ Multiple disabilities (please explain) \_\_\_\_\_  
 Other \_\_\_\_\_

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Height \_\_\_\_ Weight \_\_\_\_ BP \_\_\_\_

Code for below:     Satisfactory  
                            Not Satisfactory (please explain)  
                            Blank Not Examined

Eyes \_\_\_\_ Ears \_\_\_\_ Nose \_\_\_\_ Throat \_\_\_\_ Lungs \_\_\_\_ Skin \_\_\_\_  
 Teeth \_\_\_\_ Posture/spine \_\_\_\_ Extremities \_\_\_\_ Heart \_\_\_\_ Hernia \_\_\_\_ Abdomen \_\_\_\_

**Please give all dates of immunization for:**

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DPT		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

**Which of the following has the individual had?**

Measles \_\_\_\_ Chicken pox \_\_\_\_ German measles \_\_\_\_ Mumps \_\_\_\_  
 Hepatitis A \_\_\_\_ Hepatitis B \_\_\_\_ Hepatitis C \_\_\_\_  
 TB Mantoux Test – Date of last test \_\_\_\_\_ Result: positive \_\_\_\_ negative \_\_\_\_

**Please complete both sides of this medical →**

Today's date: \_\_\_\_\_, 2012

Name of Camper \_\_\_\_\_

**Does the individual have any allergies? Be specific ~ Explain type of reaction or symptom(s)**

Insects (be specific) \_\_\_\_\_

Seasonal/inhaled \_\_\_\_\_

Foods \_\_\_\_\_

Antibiotics (be specific) \_\_\_\_\_

Other medications (give names) \_\_\_\_\_

Other \_\_\_\_\_

**Recommendations And Restrictions While In Camp:**

Special diet: \_\_\_\_\_

Swimming, diving: \_\_\_\_\_

Strenuous activity: \_\_\_\_\_

Other: \_\_\_\_\_

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

**\*\*Signature of Physician:** \_\_\_\_\_

**Name of Physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Tel. No.:** \_\_\_\_\_ **Date this form was signed:** \_\_\_\_\_

*(If this form is not signed by a physician, we will return it to you for your physician's signature)*