

Camper's Full Name _____
 Camper's Date of Birth _____

2019 Camper Physical Form

THIS FORM TO BE COMPLETED BY A PHYSICIAN

THE OBJECTIVES OF THIS EXAMINATION ARE TO DETERMINE THAT THIS CHILD:

1. Is physically fit to engage in strenuous activities without harm to himself/herself or others.
2. Has no significant infectious condition that could be transmitted to others.
3. Has no emotional or physical disorder that could not be cared for under the routine operations and programs of Camp. Some special conditions may be handled after individual discussions with Camp.

Weight: _____ Height: _____ B.P. _____

Code: () Normal; (X) Abnormal (Explain)

- | | |
|--|--|
| <input type="checkbox"/> Skin _____ | <input type="checkbox"/> Nose _____ |
| <input type="checkbox"/> Chest _____ | <input type="checkbox"/> Extremities _____ |
| <input type="checkbox"/> Eyes _____ | <input type="checkbox"/> Throat _____ |
| <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Spine _____ |
| <input type="checkbox"/> Ears _____ | <input type="checkbox"/> Teeth _____ |
| <input type="checkbox"/> Abdomen _____ | <input type="checkbox"/> Neurologic _____ |

Menstrual History: _____

Recommendations and restrictions (diet, activity restrictions): _____

Allergies: _____

Does the camper have chronic medical problems, emotional difficulties, eating disorders or behavioral issues of which you are aware?

Yes No If yes, please describe the condition: _____

Does camper take routine medications or nutritional supplements? Yes No If yes, please list medications or nutritional supplements _____

To coincide with N.C. law for school enrollment, Organization Name require the following immunizations:

*DTP / DTaP/ DT					
**dT/Tdap					
*Polio (IPV/OPV)					
***Hib					
****Hepatitis B					
*MMR (combined doses)					
*****Chicken Pox					
**Meningococcal					

- *Required by NC State law
- **Required by State law if child is 12 years or older
- ***Required by State law for children born on or after 10/01/88
- ****Required by State law for children born on or after 07/01/94
- *****Required by State law for children born on or after 04/01/01

Date of most recent PPD (Mantoux) Test _____

Test results _____

(If indicated according to AAP recommendations in the Red Book)

Recommended immunizations received in addition to those above required:

Pneumococcal					
HPV					
Hep A					
BCG/IPPD					

Print or Stamp
 Physician's Name
 Address
 Phone Number

My signature indicates I have reviewed this form as well as examined this patient on _____ Date of Exam
 (within 12 months of arrival at Camp)

Signature of Physician _____