

## Camp Physical Examination

*This form must be completed and signed by a Licensed Physician **NOT** by a parent or caregiver.*

We request this form or a copy of our physical dated no later than **12 months** from your camp date be received in our office at least **FOUR WEEKS** before the scheduled camp session.

**Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Male** \_\_\_\_\_ **Female** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

Is any condition present, which may result in an emergency? Please describe: \_\_\_\_\_

**Allergies (Drug/Food/Environmental):** \_\_\_\_\_

### EXAMINATION COMPLETED BY PHYSICIAN

Height:	Weight:	Mouth/Throat/Nose:
Pulse:	BP:	Temp:
<b>Hearing Loss:</b> NONE PARTIAL COMPLETE Aids Worn? Cochlear Implant?		Nervous System/Reflexes/Gait/Sensations:
<b>Vision Loss:</b> NONE PARTIAL COMPLETE Glasses Worn? Contacts Worn?		Bringing to camp: CPAP or Oxygen (CIRCLE) NIGHT
Cardiac:		GI Distress - upper - lower (please specify)
Lungs:		Headaches:
Abdomen:		Bedwetting:
Musculoskeletal:		Incontinence – Urinary - Fecal (please specify)
Back/Spine:		Respiratory/Asthma/Emphysema (please specify)
Skin:		Sleep Apnea/COPD:
Diabetic: glucose monitoring:	Insulin: YES NO Frequency of	Seizures: Type: Frequency: Last:
Mobility	Uses: WALKER CANE WHEELCHAIR	

**Previous Illness** (Give age when these occurred):

Chicken Pox \_\_\_\_ Measles \_\_\_\_ Mumps \_\_\_\_ MRSA \_\_\_\_ Shingles \_\_\_\_ Herpes \_\_\_\_ Strep Throat \_\_\_\_ Hepatitis \_\_\_\_  
Frequent UTI \_\_\_\_ Frequent URI \_\_\_\_ Chronic Cough \_\_\_\_ High BP \_\_\_\_ Other \_\_\_\_\_

**Immunization History** (Please give dates (month/year) of immunizations and most recent booster dates:

DPT \_\_\_\_ MMR \_\_\_\_ Polio \_\_\_\_ Smallpox \_\_\_\_ Influenza \_\_\_\_ TB Test \_\_\_\_ Hepatitis B Series \_\_\_\_  
Tetanus \_\_\_\_ Type \_\_\_\_\_ Covid-19 \_\_\_\_\_

\*Campers ages 8-17 must attach a copy of the current immunization record. If records are unavailable, please send a statement to that effect. Statement “up-to-date” is not acceptable.

### QUESTIONNAIRE

Is camper free from communicable diseases? YES/NO If no, please describe: \_\_\_\_\_

How would you access the applicant’s current health? GOOD FAIR POOR

Has the applicant been hospitalized or treated in the emergency room in the last year? YES NO

If yes, please explain. \_\_\_\_\_

Is the applicant a carrier of Hepatitis B or C have they been exposed to Hepatitis B or C? YES NO

Are there medical reasons to limit or restrict this individual from participating in the following camp activities: swimming, supervised ropes course, hiking, and archery? \_\_\_\_\_ Any limitations? \_\_\_\_\_

Colorado State Law and Regulations require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician’s assistant) for the nurse or designated trained personnel to administer medication. Please provide complete information on all medications, including prescription and nonprescription medications, dietary supplements, and homeopathic remedies. **Nonprescription, dietary supplements and homeopathic remedies will NOT be given at camp unless prescribed by a physician.**



