Physical Exam Form for Up Camp to be completed by a licensed Physician, Nurse Practitioner, or Physician's Assistant. A medical examination must be completed within twelve (12) months of participation in camp session. Physicians may provide their own standardized form or campers may submit any form that contains the following information. Date of Appointment: ________________

Camper Full Name: ____ Nickname: ______________________________

Birth Date__________ **Gender** ______ Hair Color _________ Eye Color________ Height_________ Weight_________

Temp_______ Blood Pressure__________ Pulse _______ Respirations________ Balance/Ambulation ________________

General Appraisal: Mental Attitude/Disposition ____

EENT________________________ **Heart**______________________ **Lungs**________________ **Abdomen**_______________
Posture/Spine ________________ **Skin/Scalp** ___________________ **Extremities/Feet**________________________________

Is camper currently under care for a **chronic physical condition**? If yes, please list.

Is camper currently under the **care of a dentist or orthodontist**? If yes, please describe:

Please **list serious injuries/bone breaks or operations** in the past with year treated:

Does camper have: □ Shunt □ Glasses □ Dentures/Dental appliances □ Hearing aid(s) □ Mobility Aid(s):__________________

Does camper have a **history** of any of the following: □ Polio □ Chickenpox □ Mumps □ Measles □ Rheumatic Fever
□ Whooping Cough □ Hepatitis carrier □ Herpes Other Significant Illness History:____________________________________

Immunizations Current? _____ Except for: __________________Last **Tetanus**: _________ **TB Test**: _______Result:_________

Prone to any of the following: □ Migraines □ Ear Infections/Aches □ Bleeding/Clotting Disorder □ Dental Pain

Asthmatic Reactions: Describe Treatment: ____

Seizures: □ None □ Yes, Describe type/frequency: ____Date of last: __________

Diabetes: □ No □ Yes, Type________. Insulin: Yes No Diet Controlled: Yes No Last AIC: ________ Date: _________

Allergies: ____

Describe reaction/treatment: ____

Diet Restrictions: ____ □ Other _________________________

Physical Sensitivities: □ Insects □ Sinus Irritations □ Sunburn-prone □ Other _________________________

Any other pertinent information to assure quality care of camper at camp:

The applicant is under the care of a physician for the following medical diagnosis/disability:

Recommendations & Restrictions for Camp Activities: As a licensed medical professional, my opinion, is the above conditions *permits the applicant's participation* in an active "Up Camp" recreational program, including daily walks, water activities, fishing, archery, sleeping in tents, cooking around a campfire, and physical group games. (Circle) Yes NO

Medical reasons for limiting and/or restricting swimming, horseback riding, boating, or sleeping in tents:

I have examined the person herein described and reviewed his/her health history. It is my opinion that he/she is physically able to engage in any required activities, except as may be noted above, and is free of communicable or contagious disease.

Signature of licensed practitioner: ____
Date: _______________________ Printed Name: ____
Phone Number: _____________________ Address:____