PHYSICAL EXAMINATION

(To be filled out by Physician – please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information, which will help to serve the needs of this child in Day Camps and Afterschool and Youth Center Programs.

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

DpaP, DTP or TD Date ______ Date ______ Date ______ Date ______ Date ______

Polio\ Date ______ Date ______ Date ______ Date ______ Date ______

MMR\ Date ______ Date ______ Date ______ Date ______ Date ______

Hemophilus Influenzae type b Date ______ Date ______ Date ______ Date ______ Date ______

Hepatitus B Date ______ Date ______ Date ______ Date ______ Date ______

Varicella Date ______ Date ______ Date ______ Date ______ Date ______

* Other PPD TB ______ Date ______ 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 = No Satisfactory (Explain) 0 = Not Examined

General Appearance ______

Height ______ Weight ______ Blood Pressure ______ Hgb. Test (Date) ______

Urinalysis (Date) ______ Posture & Spine ______ Throat – Tonsils ______

Eyes ______ Vision ______ w/Glasses ______ Extremities ______ Heart ______

Ears ______ Hearing ______ Feet ______ Lungs ______ Skin ______

Nose ______ Teeth ______ Abdomen ______ Hernia ______

Genitalia ______

Neurological Findings ______

Describe Abnormal Findings and/or Handicapping Conditions ______

Has child ever received products containing horse serum? ______

Allergy: (Please specify) ______

Recommendations and restrictions while in camp.

Special Diet ______

Special Medicine (name it) ______

Is parent/guardian sending special medicine? ______

Swimming ______ Diving ______

Activity Restrictions ______

General Appraisal: ______

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