

Meadowcroft Day Camp: REQUIRED FAMILY PHYSICIAN'S REPORT - Campers & Staff

STANDARD MEDICAL OFFICE HEALTH FORMS WILL BE ACCEPTED AS THE REQUIRED MEDICAL FORM FOR CAMP

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Name: _____ Date of Birth: _____ Sex: _____ Age: _____

In an Emergency Notify: _____

IMMUNIZATIONS

DPT/ PTaP					
PPD					
Td					
OPV / IPV					
Hib					
MMR					
Hep A					
Hep B					
PCV/PPV					
Lead					
Varicella:	Illness:	Date:	Immunization	Date:	
Influenza					

ALLERGIES: _____

PHYSICAL EXAMINATION

Date of last physical exam: _____

Height:	Weight:	Nutrition:
Neurological:	Blood Pressure:	Pulse:
Skin:	Posture (Scoliosis, etc.):	Back:
Neck:	Thyroid:	Lymph Glands:
Heart:	Lungs:	Abdomen:
Skeleton:	Feet:	Reflexes:
Ears:	Nose:	Mouth:
Eyes:	Teeth:	Genitals:

Surgery / Hospitalization: _____

Lab/ X-ray: _____

Other: _____

Findings: _____

Health Care Recommendations by Licensed Physician:

The patient is under my care for the following conditions: _____

Current Treatment (include medication): _____

Explanation of any report of loss of consciousness, convulsions, or concussion: _____

Does patient have Epilepsy? _____ Diabetes: _____ Significant Illness: _____

Any treatment to be continued at camp: _____

Any medication to be administered at camp(specify dosage): _____

Any dietary restrictions: _____

Activities to be encouraged or limited: _____

Additional Health Information: _____

Licensed Physician's Signature: _____ (print name) _____

Phone: _____ Address: _____

Date Form Completed: _____