

2009 Physical Examination Record

Name _____
 Summer Camp Session _____
 Outpost trip/session _____
 Staff _____

PHYSICAL EXAM POLICY:

*You must have a **physical exam within 12 months of the session start date***

TO THE EXAMINING PHYSICIAN: We need your help! Camp Manito-wish YMCA is a resident summer camp in Boulder Junction, WI. All staff and campers are required to be physically active, and participate on canoeing, sea kayaking and backpacking trips of varying lengths. Physical activity may include:

~ Strenuous activities during hot weather ~ Carrying heavy packs and /or canoes ~ Walking on uneven terrain ~

It is important to the safety and well-being of all participants that we obtain accurate information regarding this person's current medical status and medical history.

IMMUNIZATION: You may send a copy of medical office record. Required immunizations must be determined locally. Please record the date (month/year) of basic immunizations and most recent booster doses.

VACCINES	Date of Basic Immunization	
Diphtheria Pertussis (Whooping Cough) Tetanus	DPT/DTaP	1. 2. 3.
Tetanus Diphtheria	or TD	
Injectable Polio (Salk)		
Oral Polio (Sabin)	TOPV	
Tetanus		
Measles, Mumps, Rubella, or MMR		
Pneumococcus (Prevnar)		
Hepatitis B (HBV)		
Hemophilus Influenza type B (HIB)		
Meningococcus		
Other		

STAFF ONLY: Tuberculin test given _____ Administer Mantoux _____ neg/pos Chest x-ray if nec. _____
 (must be within 12 months of start date for Staff) DATE _____ DATE _____
 Have you been out of the country in the last year? Y / N If yes, where? _____
 Date of Return to States _____

ALLERGIES: (For example: Medications, Insect Stings, Environmental, Food)

Allergy (list below)	Reaction	Medication Required

PHYSICIAN'S PROGRESS NOTE OR SPECIAL INSTRUCTIONS:

****If the participant has diabetes or anaphylactic reactions, please be sure to provide complete treatment information.**



PHYSICAL EXAMINATION

(To be filled out by licensed physician)

Name _____

Code: S - Satisfactory NS - Not Satisfactory (explain) O - Not Examined

Height _____ Weight _____ B.P. _____ Hct. or Hgb. Test _____

Eyes _____	Hernia _____	ALLERGY: _____
Glasses _____	Extremities _____	_____
Ears _____	Including: _____	_____
Nose _____	Shoulder _____	_____
Throat _____	Knees _____	_____
Heart _____	Ankles _____	GENERAL APPRAISAL: _____
Genitalia _____	Feet _____	_____
Lungs _____	Posture (Spine) _____	_____
Abdomen _____	Skin _____	_____

For Females: Has this person menstruated? _____ If not, has she been educated about menstruation? _____
If so, is her menstrual history normal? _____ Special considerations: _____

Recommendations and restrictions while in camp:

Special Diet _____	
Current Medications _____	**Is parent sending it? _____
Strenuous Activity _____	(see below)
Other _____	

TO EXAMINING PHYSICIAN: Please list all Physician Orders for medication or treatment, including vitamins and homeopathic treatments.

**The Camp RN will only administer medications for which information is completed below.

MEDICATION	Medication	Dosage	Freq (# days)	route	if prn - indicate reason

TREATMENTS _____

If participant is on psychiatric medications, for how long have they been on their current medication routine (dose and frequency)? _____

If a change has been made in that last three months, please give more information. _____

PHYSICIAN'S SIGNATURE REQUIRED:

On the basis of your knowledge of the applicant, the applicant's medical history, the present physical examination of this applicant, and your knowledge of the activities in which they will be asked to participate, do you feel this individual is able to participate in the Camp Manito-wish program? YES _____ NO _____

Name of Physician (Please Print): _____

Complete Address: _____

Telephone: () _____ Email: _____

Physician's Signature _____ Date _____