



500 Illahee RD Brevard NC 28712
 Phone (828) 883-2181 Fax (828) 883-8738

PHYSICAL EXAM

BY PHYSICIAN

DUE MAY 1

*(must be completed within 12 months of camp
 parent information and signature also needed on back!)*

CAMPER'S NAME: _____ **DOB (mm/dd/yyyy):** _____

Age _____ Height _____ Weight _____ BP _____ Pulse _____

Severe Allergies _____ Requires Epinephrine? ____ Yes ____ No

List other allergies: _____

Does/Has the camper have/had: (please explain "yes" answers below.)

	Yes	No		Yes	No
Recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	Orthopaedic Problems?	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>	Constipation/diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>
Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Skin problems (itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	ADD or ADHD?	<input type="checkbox"/>	<input type="checkbox"/>
Head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent ear infections in the last two years?	<input type="checkbox"/>	<input type="checkbox"/>	Use an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
Fainting, dizziness, chest pain during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
Seizures?	<input type="checkbox"/>	<input type="checkbox"/>	History of bedwetting in last two years?	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal menstruation history?	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Professional help for emotional difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox ?	<input type="checkbox"/>	<input type="checkbox"/>	Flu within the past year?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain "yes" answers:

Please list any RESTRICTIONS from normal activity while at camp:

Camp is NOT a good time to take a "vacation" from any normal medications. Please indicate any medications camper will continue at camp, their dosage(s) and purpose:

I have examined the camper listed and reviewed her health history, and have attached a copy of her immunization records. It is my opinion that she is physically and emotionally capable of living in a community setting and participating in an active camp program with the restrictions noted.

Examining physician's signature

Date

()

Physician's printed name and address

Telephone number

(over for parent signature)

MEDICAL TREATMENT DURING SUMMER PROGRAM:

On behalf of my child, I hereby grant permission for physicians, dentists and other licensed health care providers selected by Camp Illahee to provide medical or dental services that may be needed by my child, as reasonably determined by Camp Illahee, while participating in the Summer Program, and I agree I will be financially responsible for any charges associated with such services including prophylactic treatment due to exposure to insects or animals.

Parent Signature (required): _____

Date: _____

Parent Contact: _____ Phone Number: _____
(Please Print)