PHYSICAL EXAM

BY PHYSICIAN
DUE JUNE 1
To be completed within 12 months of camp
Parent signature required on back

CAMP
ILLAHEE
EST. 1921

PLEASE RETURN
500 ILLAHEE ROAD
BREVARD, NC 28712
Phone (828)883-2181
Fax (828)883-8738

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?	❑	❑	Heart Murmer?	❑	❑
Chronic or recurring illness/condition?	❑	❑	Orthopaedic Problems?	❑	❑
Hospitalization?	❑	❑	Constipation/diarrhea?	❑	❑
Surgery?	❑	❑	Skin problems (itching, rash, acne)?	❑	❑
Frequent headaches?	❑	❑	ADD or ADHD?	❑	❑
Head injury or concussion?	❑	❑	Diabetes?	❑	❑
Wear glasses, contacts or protective eyewear?	❑	❑	Asthma?	❑	❑
Frequent ear infections in the last two years?	❑	❑	Use an inhaler?	❑	❑
Fainting, dizziness, chest pain during exercise?	❑	❑	Problems with sleepwalking?	❑	❑
Seizures?	❑	❑	History of bedwetting in last two years?	❑	❑
Abnormal menstruation history?	❑	❑	Eating disorder?	❑	❑
High blood pressure?	❑	❑	Professional help for emotional difficulties?	❑	❑
Chicken Pox ?	❑	❑	Flu within the past year?	❑	❑

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 ***Prescription or Over-the-counter*** *medications campers will continue to take 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)