PHYSICAL EXAM

signed by ***PHYSICIAN and PARENT***
DUE MAY 15th
To be completed within 12 months of camp

CAMP
ILLAHEE
EST. 1921

PLEASE RETURN
500 ILLAHEE ROAD
BREVARD, NC 28712
P:(828)883-2181
F: (828)883-8738
E: claire@campillahee.com

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

Age _____ Height _____ Weight _____ BP _____ Pulse _____

PARENT CONTACT: _____ **Cell Phone #** ( ) _____

Camper Allergies: _____ **Requires Epinephrine?** Yes ❑ No ❑

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

	Yes	No
Recent injury, illness or infectious disease?	❑	❑
Chronic or recurring illness/condition?	❑	❑
Hospitalization?	❑	❑
Surgery?	❑	❑
Frequent headaches or concussion?	❑	❑
Wear glasses, contacts or protective eyewear?	❑	❑
Frequent ear infections in the last two years?	❑	❑
Fainting, dizziness, chest pain during exercise?	❑	❑
Seizures?	❑	❑
Abnormal menstruation history?	❑	❑
Mononucleosis in past year ?	❑	❑
Tested Positive for COVID-19 in past year?	❑	❑
Date of Positive Test: _____		

	Yes	No
Orthopeadic Back/Joint Problems?	❑	❑
Constipation/diarrhea?	❑	❑
Skin problems (itching, rash, acne)?	❑	❑
ADD or ADHD?	❑	❑
Asthma/Wheezing/Shortness of Breath?	❑	❑
Use an inhaler?	❑	❑
Problems with sleepwalking or Falling Asleep?	❑	❑
History of bedwetting in last two years?	❑	❑
Eating disorder, Anxiety or Depression?	❑	❑
Professional help for emotional difficulties?	❑	❑
COVID-19 Vaccination	❑	❑
Dates administered: #1 _____ #2 _____		
Booster _____		

Please explain "yes" answers and include any applicable dates, except for COVID dates already listed. Use back if necessary:

_____

Please list any RESTRICTIONS from normal activity while at camp. Use back if necessary:

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*

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 participting 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*