PHYSICAL EXAM
Signed by **PHYSICIAN & PARENT**
DUE MAY 15th
Complete within 12 months of camp
PLEASE ATTACH
IMMUNIZATION RECORD

CAMP
ILLAHEE
EST. 1921

PLEASE RETURN
500 Illahee Road
Brevard, NC 28712
P: (828) 883-2181
F: (828) 634-7590
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		Yes	No
Recent Injury, illness or infectious disease?	☐	☐	Orthopedic Back/Joint Problems?	☐	☐
Chronic or recurring illness/condition?	☐	☐	Constipation/Diarrhea?	☐	☐
Hospitalization?	☐	☐	History of bedwetting in past year?	☐	☐
Surgery?	☐	☐	Skin problems (itching, rash, acne)?	☐	☐
Frequent Headaches or concussion?	☐	☐	ADD or ADHD?	☐	☐
Wear glasses, contacts or protective eyewear?	☐	☐	Asthma?wheezing/shortness of breath?	☐	☐
Frequent ear infections in the last 2 years?	☐	☐	Use an inhaler?	☐	☐
Fainting, dizziness, chest pain during exercise?	☐	☐	Problems with sleepwalking or falling asleep?	☐	☐
Seizures?	☐	☐	Eating disorder, anxiety or depression?	☐	☐
Abnormal menstruation history?	☐	☐	Professional help for emotional difficulties?	☐	☐
			Mononucleosis in past year?	☐	☐

Please explain "yes" answers and include any applicable dates:

_____

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 and date ***Physician's printed name, address and telephone #***

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 and date, REQUIRED_____