MEDICAL EXAM

PHYSICIAN COMPLETES THIS SIDE

ATTACH EXTRA SHEET IF NEEDED

Please return this form to Katie Radeke/R.O.C.K. 507 Huntington Dr. S Sartell, MN 56377

Name of Camper – Last, First, Middle Age Sex Date of Examination

Diagnosis and Physical Disability

Blood Pressure Height Weight

Positive Physical Findings

List all medications the camper is now taking. Please indicate which will be necessary during the camp session.

Medication	Dosage	Frequency

Describe any allergies/sensitivities:____

Give details of any special concerns (decubitus ulcers, open sores, catheters, irrigations, ear tubes, enemas, medically prescribed diet, etc.)____

List exercise or therapy required during camp session____________________________________

List restrictions: o No swimming o No outside overnights o Other (specify)________________

Does camper have a history of seizures? o yes o no *If yes, please fill out information below. If no, skip this section.*

Date of last seizure_______________Type______________Frequency of occurrence______________
Medically controlled? o yes o no

Date of last tetanus toxoid___________***Should be administered with this physical if not up to date.***

Current tuberculosis test result & date (must be within 2 years)______________________________

Chest x-ray results if positive mantoux____

THIS FORM MUST BE SIGNED BY PHYSICIAN

Print Physician's Name Physician Signature

Current Address Number and Street or Route City/State/Zip Phone

FOR CAMP USE ONLY

Admission Date________________________________Temperature________________________Pulse________________

HEALTH FORM

CAMPER COMPLETES THIS SIDE
PHYSICIAN COMPLETES REVERSE SIDE

GENERAL INFORMATION (Please Print)

____
Name of Applicant – Last, First, Middle   Age   Sex   Date of Birth (M/D/Y)

____
Current Address   Number and Street or Route   City/State/Zip

____
Home Phone (include area code)   Work Phone (if applicable, include area code)

____
Emergency Contact Name   Relationship to Applicant

____
Home Phone (include area code)   Work Phone (include area code)

MEDICAL INFORMATION *please attach extra sheet if additional space is needed*

____
List all type(s) of physical disability (including Deaf/HOH)   Date of onset

____
List operations/serious illnesses/injuries with approximate dates

____
List any other disorders (communication disorders, mental disabilities, emotional disorders, learning disabilities, etc.)

____
Primary Care Physician Name   Address   Phone Number (include area code)

____
Specialist Name (if applicable)   Phone Number (include area code)   Recommendations

____
List Restrictions/Special Needs (if any)

____
List diet modification (if any, please include gluten-free diet)

HEALTH HISTORY *Check all that apply and give approximate dates*

o Frequent Ear Infections_____   o Mononucleosis_______   o Hay Fever_______
o Heart Defect/Disease______   o Chicken Pox_________   o Poison Ivy_______
o Convulsions_______________   o Measles____________   o Insect Sting______
o Diabetes_________________   o German Measels______   o Asthma__________
o Bleeding Disorder__________   o Mumps______________   o Medications_______
o Hypertension_______________   o Allergies_____________   o Other____________

Immunizations
Are immunizations up to date? o yes o no
List Dates of last booster:
DTP_______________MMR_______________

Polio_____________Other______________

Menstrual History (females only)
Has camper begun menstruation? o yes o no
Has she been informed about menstruation? o yes o no
Special considerations/irregular menstrual patterns

____