



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 6 months
 of camp session)

CAMPER'S NAME: _____

Age _____ Height _____ Weight _____ BP _____ Pulse _____

Allergies _____ Requires Epinephrine? ____ Yes ____ No

Allergic to Penicillin? ____ Yes ____ No List allergy to other Meds: _____

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 knocked unconscious?	<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"/>
Normal 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 and note the number of the question:

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 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

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 Physician's printed name and address

 Telephone number

CAMP USE ONLY Meds Rec'd _____

Notes _____

By: _____ Date Screened _____

