

PHYSICAL EXAM

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



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		Yes	No
Recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Back/Joint Problems?	<input type="checkbox"/>	<input type="checkbox"/>
Chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	Constipation/diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>	Skin problems (itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	ADD or ADHD?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Wheezing/Shortness of Breath?	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	Use an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent ear infections in the last two years?	<input type="checkbox"/>	<input type="checkbox"/>	Problems with sleepwalking or Falling Asleep?	<input type="checkbox"/>	<input type="checkbox"/>
Fainting, dizziness, chest pain during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	History of bedwetting in last two years?	<input type="checkbox"/>	<input type="checkbox"/>
Seizures?	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder, Anxiety or Depression?	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal menstruation history?	<input type="checkbox"/>	<input type="checkbox"/>	Professional help for emotional difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis in past year ?	<input type="checkbox"/>	<input type="checkbox"/>	COVID-19 Vaccination	<input type="checkbox"/>	<input type="checkbox"/>

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

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 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