Camp 603

PHYSICIAN'S EXAM REPORT

Child's name: _____

DOB: _____ Age: _____ Sex: M F

Allergies (including medications and insect stings): _____

_____

Health history (please check all that apply):

Chicken Pox	____	Asthma	____	Seizures	____
Joint/Bone problems	____	Ear infections	____	Strep throat	____
Headaches	____	Operations	____	Bed wetting	____
Skin conditions	____	Hospitalizations	____	Other	____

Please explain any health concerns checked above: _____

_____

Current medical diagnosis: _____

Current medications:

Medication Dosage and time Reason for

_____

_____

_____

Immunizations:

DTP, Td, DT						
Polio						
MMR						
Hep B						
Varivax						
HIB						
Other						

Last TB test: _____ Results: _____

Height: _____ Weight: _____ BP: _____

☐ Capable of full participation in camp activities including gymnastics and athletics

☐ Limited participation as explained below

_____

_____

Physician's signature: _____ Date: _____

Physician's name: _____ Phone #: _____

Address: