Carmans River Adventure Day Camp

Medical forms must be completed by a health care provider- MD. RPAC OR NP the date of the physical must be within one year of the last day of camp attendance.

Camper's:

Name:_____ DOB:_____

Address:_____

RECORD OF IMMUNIZATION AND TESTS- Please give DATES (month, day and year)

Polio:_____

Measles #1_____ #2_____ Mumps: _____ Rubella:_____ or MMR #1_____ #2_____

Triple vaccine (DTP, DtaP, DT, Td): _____ _____ _____ _____ _____ _____ _____

Tetanus: _____ _____ _____ Hepatitis B: 1# _____ 2#_____ 3#_____

Varicella: _____ Hib: _____ 1#_____ 2#_____ 3#_____ 4#_____

TB Test: Date: _____ Negative: ▢ Positive: ▢

Chest X-Ray: Date: _____ Results: _____

PHYSICAL EXAMINATION:

Height: _____ Weight: _____ Scoliosis Screening: Positive: ▢ Negative: ▢

Eyes: L_____ R_____ Teeth:_____ Skin:_____ Speech:_____

Ears (otoscope) L_____ R_____ Heart:_____ Lungs:_____

Epilepsy:_____ Nervous System:_____ Urinary:_____ Hernia:_____ Lymph Nodes:_____

Thyroid:_____ Diabetic:_____ Nutrition:_____ Orthopedic:_____ Other:_____

Nose:_____

Tonsils:_____

A. Structural
B. Posture
C. Feet

Recommendations for physical activity and camp:

A. Full physical activity
   Yes ▢ No▢
B. Modified physical activity because of

_____

_____

_____

Signature of Healthcare Provider:

_____

Date of Exam:

_____

Print Name & Title or Stamp:

_____