Camp Evergreen Physical Form

This form must be completed by a physician and returned prior to the camper's admission to camp. No camper will be allowed admission without a signed physical form on file.

Camper's Name: _____Date of Birth:_____

Height: _____ Weight: _____ Temperature: _____ Pulse: _____

Blood Pressure: RA _____ LA _____

I have examined the above named patient and find him/her to be free of contagious diseases and to have no acute or chronic physical conditions: ☐ Yes ☐ No (Explanation if no):

Immunization History

Type of Vaccine	First Dose Mo/Day/Year	Second Dose Mo/Day/Year	Third Dose Mo/Day/Year	Fourth Dose Mo/Day/Year	Fifth Dose Mo/Day/Year
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent Booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio					
Hepatitis B					
MMR					
Varicella (Chickenpox) Vaccine Vaccine is required only if camper has not had chickenpox disease. See below.					

Has the camper has Varicella (chickenpox) disease?
☐ Yes _____ year (vaccine not required)
☐ No or Unsure (vaccine required)

Blood/Body Fluid Precaution? ☐ Yes ☐ No (Explanation if yes):

Within Normal Limits		Abnormalities
Ears	☐ Yes ☐ No	
Eyes	☐ Yes ☐ No	
Mouth/Throat	☐ Yes ☐ No	
Nose	☐ Yes ☐ No	
Glands	☐ Yes ☐ No	
Lungs	☐ Yes ☐ No	
Heart	☐ Yes ☐ No	
Abdomen	☐ Yes ☐ No	
Skin	☐ Yes ☐ No	
Scalp	☐ Yes ☐ No	
Back	☐ Yes ☐ No	
Varicosity's	☐ Yes ☐ No	
Neurological	☐ Yes ☐ No	
Extremities	☐ Yes ☐ No	

Is there a history of:		Explanation if yes
Asthma	☐ Yes ☐ No	
Hernia	☐ Yes ☐ No	
Enuresis	☐ Yes ☐ No	
Fevers	☐ Yes ☐ No	
Kidney Disease	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Hepatitis	☐ Yes ☐ No	
Heart Disease	☐ Yes ☐ No	
Surgery	☐ Yes ☐ No	
Colds/Hay fever	☐ Yes ☐ No	
Stomach Disorders	☐ Yes ☐ No	
Weight Gain/Loss	☐ Yes ☐ No	

Please list any allergies to foods, insect bites, medication, etc.

May the camper be given: Tylenol ☐ Yes ☐ No

May the camper participate in the following activities:

Water Activities (swimming, wading, etc.) ☐ Yes ☐ No

Physical Activities (kick ball, softball, hiking, etc.) ☐ Yes ☐ No

Other activity limitations:_____

Does this person use any special equipment (wheelchair, walker, dentures, hearing aid, etc.)? ☐ Yes ☐ No

(Explanation if yes):_____

If there is any history of convulsive disorder, please complete the following:

Clinical Type: _____

Date of Last Seizure: _____/_____/_____ Frequency of Seizures: _____

When are seizures most likely to occur? _____

When should medical assistance be sought? _____

Physician's Signature: _____Date:_____/_____/2017

Please print name: _____

Return completed physical form to: Camp Evergreen
2776 N. 31st Place
Sheboygan, WI 53083