Physician's Form

(Must be completed by a licensed physician)

Applicant's Name ____________________

Medical Diagnosis ____________________

Height ________ Weight ________ Pulse ________ Blood Pressure ________

Urinalysis Done? ________ Hgb. Done? ________ Tine Test ________

Eyes ____________________

Glasses ____________________

Contacts ____________________

Ears ____________________

Nose ____________________

Mouth ____________________

Throat ____________________

Teeth ____________________

Heart ____________________

Lungs ____________________

Lymph Nodes ____________________

Abdomen ____________________

Genitalia ____________________

Hernia ____________________

Extremities ____________________

Posture (Spine) ____________________

Skin ____________________

Allergy (Please specify) ____________________

____

Menstrual History ____________________

General Appraisal ____________________

____

Medication

Only medication listed on this form or authorized by the camp physician will be administered at camp. All medication must be brought to camp in the original prescription bottle.

Name of Medication	Dosage	Administration

(Continued on other side)

Physician's Report (Continued)

Immunization Record (Write in date of applicant's last booster)

DTaP ________________ Td Booster ________________ Hep B ________________

Hib ________________ Polio ________________ Varicella ________________

MMR ________________ Measles Dose 2 ____________ Other ________________

Swimming

Is applicant permitted to swim in a lake? ____

List any swimming restrictions ____

Diet and Environment

Applicant's allergies ____

Applicant's special diet ____

____

Additional comments, restrictions or recommendations ____________________________________

____

Physician's Name ____

Office Address ____

____

Office Phone Number ____

Physician's Signature ____ **Date** _______________