

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 _____

Abdomen _____

Glasses _____

Genitalia _____

Contacts _____

Hernia _____

Ears _____

Extremities _____

Nose _____

Posture (Spine) _____

Mouth _____

Skin _____

Throat _____

Allergy (Please specify) _____

Teeth _____

Heart _____

Menstrual History _____

Lungs _____

General Appraisal _____

Lymph Nodes _____

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** _____