Medical Information KIDS CAMP 2017

Physical Examination Form for your family doctor to complete (part 1 of 3)
(Please Print)

Full name of camp applicant: _____

Date of birth: ____/_____/ _____ **Date of exam: ____/____/ 20____**

Height: _____ Weight: _____lbs. Blood Pressure: _____ Hair color: _____

Eye color: _____

Health History

	Yes	**No**
Frequent Ear Infections	_____	_____
Cardiovascular Disorders	_____	_____
Epilepsy/Seizures	_____	_____
Diabetes	_____	_____
Bleeding/Clotting Disorders	_____	_____
Asthma	_____	_____
Chicken Pox	_____	_____
Recent Concussions or Head Trauma	_____	_____
Vision Problems	_____	_____
Mobility Problems	_____	_____
Social / Emotional Disorders	_____	_____

Explanation:
_____

Allergies (please list if "yes") _____ _____

_____

Other:
_____

Major surgeries or serious injuries? _____

Chronic illnesses? _____

Physical Limitations? _____

Dietary restrictions or requirements?
_____

Additional handicaps and aid requirements?
_____

Medical Information KIDS CAMP 2017

Physical Examination Form for your family doctor to complete (part 2 of 3)

Student Name:

_____

___This child MAY participate in all camp activities

___This child MAY NOT participate due to the following restrictions:

_____

Current medication/s: Physician's written orders must be submitted with all prescription medications:

(All medications must be in original containers. NO unmarked bottles or baggies are accepted.)

(Please attach a copy of Immunization Record)
Immunization History: (Tetanus must be within past TEN years. If not, a booster is required.)

The above applicant has been examined by me.

Licensed physician's name (please print):
_____

Physician's
signature_____

Address:
_____

_____

Date: _____ Telephone number: ( )_____

Parent/Guardian
signature_____Date: _____

PARENT/GUARDIAN: PLEASE SEND THIS PAGE BACK TO Doug Boersma

Kids in Camelot!

2017 KIDS Camp

PHYSICIAN'S REQUEST FOR MEDICATION ADMINISTRATION (3 of 3)

Student Name: _____DOB: _____

Diagnosis: _____
Medication: _____
Route of Administration: _____
Dosage: _____
Frequency Schedule: _____
Adverse Reactions/Side Effects: _____
Length of Order: _____

Please provide any information you feel would be helpful to the camp staff or health office:

_____
_____

_____ _____
Physician Signature Date

_____ _____
Address Telephone & Fax No:

_____ _____
Parent Signature Emergency Phone Numbers

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