Physical / Immunization Form

PHYSICAL EXAM

Camper's Name: ___________________________________ Date of Birth_____________

The above patient was examined on_________________.

The patient's health history and immunization records were reviewed.

Weight:___________ Height:___________ BP:___________

Vision: Left___________ Right___________ Color___________ Postural Screen___________

Allergies:____

____

Chronic Medical Problems:____

____

Medications/Treatments:____

____

Dietary Restrictions:____

____

I SEE NO REASON (S) TO RESTRICT FULL PARTICIPATION IN CAMP ACTIVITIES.

Physician's Name (Printed): ______________________________ Phone #:________________

Physician's Signature: ___________________________________ Date:___________________

PARENTS: I CERTIFY THAT MY CHILD HAS NOT INCURRED ANY SIGNIFICANT HEALTH PROBLEM (S) SINCE THE DATE OF THE ABOVE PHYSICAL EXAM.

Parent's Signature: ___________________________ Date:____________ continued on back

IMMUNIZATION RECORD WITH MONTH/YEAR OF ADMINISTRATION

DPT/DTaP/DT	OPV/IPV	HIB	Hept B	LEAD Date/Result
	MMR	Varivax	Influenza Vacc	TB Risk Screen
Td				
Other Immunizations		Chicken Pox		