

# LA VIDA ADVENTURE CAMP PHYSICIAN'S FORM

This form must be completed by a licensed health care provider and returned prior to attending camp. A signed photocopy of the camper's immunization records and a signed physical from the last 18 months will also be accepted as a replacement for this physician's form.

Camper name \_\_\_\_\_ Sex:  Female  Male  
Last First Middle initial  
 Height \_\_\_\_\_ inches Weight \_\_\_\_\_ pounds Blood pressure \_\_\_\_\_  
 Birth date (mo/day/yr) \_\_\_\_\_ Age: years \_\_\_\_\_ months \_\_\_\_\_

## SYSTEMS REVIEW

Are there any abnormalities of:

	NO	YES	COMMENTS
Head, eyes, ears, nose, throat			
Vision, hearing			
Skin			
Respiratory system			
Cardiovascular system			
Musculoskeletal system			
Central nervous system			
Abdomen			
Genitalia			
Menstruation			

## IMMUNIZATION HISTORY

Please record the number of each immunization and the month/year of the most recent dose.

<b>Measles (MMR)</b> Dates _____	<b>Tetanus</b> Date _____	<b>Polio (IPV, OPV)</b> Date _____	<b>Tuberculin test</b> Results _____	<b>Lead test</b> Results _____
<b>Diphtheria, pertussis, tetanus (DPT)</b> Date _____	<b>Tetanus/diphtheria (TD)</b> Date _____	<b>Haemophilus influenzae type b (Hib)</b> Date _____	<b>Hepatitis B</b> Date _____	<input type="checkbox"/> Varicella vaccine or <input type="checkbox"/> Chickenpox Date _____


## KNOWN ALLERGIES AND TREATMENT

Food \_\_\_\_\_ Medication(s) \_\_\_\_\_  
 Environment \_\_\_\_\_ Insect(s) \_\_\_\_\_

## MEDICATIONS AND HEALTH INFORMATION

Is the camper currently under the care of a physician?  Yes  No If yes, why? \_\_\_\_\_  
 Recommendations for physical activity:  Unlimited  Limited  
 Define activities to be restricted if any \_\_\_\_\_  
 Current medications or treatment \_\_\_\_\_  
 Medications to be taken at camp (including sunscreen, inhalers, etc.) \_\_\_\_\_  
 Additional health information \_\_\_\_\_

I have examined the person herein described and have reviewed the health history. It is my opinion that this person is able to engage in and participate in all camp activities unless otherwise noted above.

 Physician signature \_\_\_\_\_ Date\* \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

\*Examination date must be within 18 months of Adventure Camp