**Date of Birth:**

**SECTION III: Medical Examination**

A medical examination is required for overnight camps and must be completed and signed by a licensed physician, nurse practitioner, physician’s assistant or registered nurse within the preceding 12 months (other physical/examination forms are excepted if exam was completed in the preceding 12 months and signed by the physician). Please call us if you have any questions.

# Medical Examination – Must be completed in detail.

|  |  |
| --- | --- |
| B. P.: | |
| Hearing: | R L |
|  | |
|  | Urinalysis\* |
|  | HGB\* |
|  | Appearance/Nutrition |
|  | General Physical State |
|  | General Emotional State |
|  | Other: |

|  |  |  |  |
| --- | --- | --- | --- |
| Height: | |  | Weight: |
| Eyes: With Glasses | R 20/ | L 20/ | |
| Eyes: With Glasses | R 20/ | L 20/ | |

Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

|  |  |
| --- | --- |
|  | Nose |
|  | Throat |
|  | Teeth |
|  | Heart |
|  | Lungs |

|  |  |
| --- | --- |
|  | Abdomen |
|  | Hernia |
|  | Genitalia |
|  | Skin |
|  | Musculoskeletal |

\*Girl should have this test if she has not had it since entering puberty.

# Record of Immunization – Must be completed in detail.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date Series was Year of Last Booster Date Series was Year of Last Booster  Completed Completed | | | | | | |
| Hep B |  |  |  | Typhoid |  |  |
| DTap/Tdap |  |  | Paratyphoid |  |  |
| DT/Td |  |  | Cholera |  |  |
| Hib |  |  | Yellow Fever |  |  |
| IPV/OPV |  |  | Typhus |  |  |
| PCV7 |  |  | Rocky Mountain |  |  |
| MMR |  |  | Spotted Fever |  |  |
| Varicella |  |  | Tuberculin Test: Year last given |  |  |
|  | | | | | Result |  |
| Other: Not required immunizations, but recommended | | | | | | |
|  |  |  |  | HPV |  |  |
|  |  |  | Rota |  |  |
|  |  |  | MCV4/MPSV4 |  |  |
|  |  |  | Hep A |  |  |
|  |  |  | TIV/LAIV |  |  |

Personal and religious beliefs dictate against immunizations: Yes No **Physician Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Licensed Physician Name: (Last, First, Middle Initial) | Phone Number: | | |
| Address: | City: | St: | Zip: |
| This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as  noted. | | | |

# Signature of Licensed Physician: State License Number: Date: