2010 Camper Health Examination Form

***This form must be completed by a licensed physician to verify that the camper has had a health examination within 24 months prior to camp attendance.**

Camper Name:__________________________________ Birth Date:__________ Age at Camp____
(Last) (First) (MI)

Gender: *Male* *Female* Custodial Parent/Guardian:____

Medical Exam

Exam Date:___________ Height:________ Weight:________ Pulse:________ BP______/______

Vision: R 20/______ L20/______ Corrected: *Y* *N* Contacts: *Y* *N* Hearing: R_____ L_____

Exam	Normal	Abnormal Notes
Appearance	Y / N	
HEENT	Y / N	
Eyes	Y / N	
Fundoscopic	Y / N	
Pupils	Equal/Unequal	
Ears/Nose	Y / N	
Hearing	Y / N	
Throat	Y / N	
Dental	Y / N	
Lymph Nodes	Y / N	
Thyroid	Y / N	
Heart	Y / N	
Murmurs	Y / N	
Pulses	Y / N	
Lungs	Y / N	
Abdomen	Y / N	
Genitourinary (Male)	Y / N	
Hernia	Y / N	
Skin	Y / N	
Musculoskeletal		
Neck	Y / N	
Back	Y / N	
Shoulder/Arm	Y / N	
Elbow/Forearm	Y / N	
Wrist/Hand/Fingers	Y / N	
Hip/Thigh	Y / N	
Knee	Y / N	
Leg/Ankle	Y / N	
Foot/Toes	Y / N	
Duck Walk	Y / N	

Notes:____

CYC, 2131 Fairview Ave N, Roseville, MN 55113—Phone (651) 636-1645/FAX (651)628-9323
Website: www.cycamp.org E-mail: office@cycamp.org

Please return form one month prior to registered camp session.

2010 Health Examination Form Continued…

Camper Name:______________________________ Birth Date:_________
(Last) (First) (MI)

Allergies:

- ☐ No known allergies
- ☐ To foods ***(list):***
- ☐ To medications ***(list):***
- ☐ To the environment ***(insect stings, hay fever, etc.-list):***
- ☐ Other allergies ***(list):***

Describe previous reactions:

Diet/Nutrition:

- ☐ Eats a regular diet.
- ☐ Has a medically prescribed meal plan or dietary restrictions ***(describe below):***

Is the camper undergoing treatment at this time?

- ☐ No
- ☐ Yes ***(describe the camper's condition[s]):***

Medication:

- ☐ No daily medications.
- ☐ Will take the following prescribed medication(s) while at camp ***(describe below—name, dose, frequency):***

The camper will require activity limitations or restrictions while at camp:

- ☐ No
- ☐ Yes ***(describe and offer recommendations—attach additional information if needed):***

I have personally examined this camper within 24 months prior to camp attendance, and it is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Name of licensed medical personnel ***(please print)***:________________________________ Title:_______________

Signature:____ Date:_________________________________

Office Address:____
Street City State Zip Code

Telephone: (_____)______________________________ Fax Number: (_____)______________________________

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