Physical Examination Form: Summerside Camps

DUE: PRIOR TO YOUR CAMPERS ***FIRST DAY*** AT SUMMERSIDE CAMPS

Camper Name: _____

Grade in September 2021: _____ Birth Date: _____ Gender: _____

BELOW SECTION to be completed by Physician or Licensed Medical Professional

Date of Physical Examination: _____

Height: _____ Weight: _____ BP: _____/_____ Pulse: _____

Medication/Food Allergies and Reaction:

_____

_____

_____

__

Treatment required for allergic reaction: ▫ Inhaler ▫ EpiPen ▫ Antihistamine ▫ Other:

History of anaphylaxis or emergency treatment for allergic reaction: ▫ Yes ▫ No

Medication(s) taken on a regular basis: _____

Medication(s) dispensed during or after school:

_____

Tuberculosis History Survey: ▫ Pass ▫ Fail — Follow up: _____

Scoliosis Screening: ▫ Pass ▫ Fail — Follow up: _____

Hearing Test: ▫ Pass ▫ Fail — Follow up: _____

Vision Test: ▫ Pass ▫ Fail — Follow up: _____

Current Health Problems (please check all that apply & explain on next page):

▫ ADD/ADHD
▫ Dizziness/fainting
▫ Neurological
▫ Anxiety
▫ Gastrointestinal
▫ Nose/throat
▫ Asthma
▫ Genitourinary
▫ Respiratory
▫ Athletic injury
▫ Hair/scalp
▫ Seizures/convulsions
▫ Behavioral/emotional
▫ Hearing
▫ Skin
▫ Bladder
▫ Heart
▫ Speech
▫ Bleeding disorder
▫ Kidney
▫ Surgical history
▫ Cardiac
▫ Liver
▫ Tuberculosis exposure
▫ Dental
▫ Lung
▫ Vision
▫ Depression
▫ Lymph glands
▫ Developmental delay
▫ Migraines/headaches
▫ Diabetes
▫ Musculoskeletal

▢ Other:

▢ Chemical dependency: ▢ Drugs ▢ Alcohol
▢ Concussion: # of concussions _____Date of last concussion: _____

Please explain Current Health Problem(s): _____

_____

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_____

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_ Other medical information of which the SCH school nurses and counselors should be aware:

_____

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Permission to Participate

I have reviewed the health history and examined the aforementioned student and find him/her to be physically qualified to participate in all physical education classes, sports games, athletic practices, competitive games, and contests, for the months of June/July/August , *except* for the following:

_____

_____

_____

Medical Professional PRINTED name: _____

Medical Professional Signature: _____ **Signature Date:** _____

Note to Physician or Medical Professional:

Please provide a complete Record of Immunization with this form.