Physical Information

(To be completed by a licensed physician, nurse practitioner or physician assistant; Must be dated **after** (8/6/20)

CAMPER NAME: _____ Height _____ Weight: _____

Allergies: _____

Check if there are any abnormalities with the following

	Yes	No	Comments		Yes	No	Comments
General	☐	☐	_____	Heart	☐	☐	_____
Skin	☐	☐	_____	Lungs	☐	☐	_____
HEENT	☐	☐	_____	Abdomen	☐	☐	_____
Lymph nodes	☐	☐	_____	Other:	☐	☐	_____

Please check whether the patient has the following:

	Yes	No		Yes	No		Yes	No
Recent Hospitalizations	☐	☐	Lab Abnormalities	☐	☐	Communicable Diseases	☐	☐
Chronic Illness	☐	☐	Neurologic Deficit	☐	☐	Physical Disabilities	☐	☐
Hearing/Vision Deficit	☐	☐	Asthma	☐	☐	Seizures	☐	☐

If yes to any of the above, please comment: _____

_____

Immunization History

Varicella:

Date: _____ If not vaccinated, has patient had Varicella or Zoster? ☐ **YES** ☐ **NO**

Tetanus:

Date of most recent Tetanus Vaccine/Booster (DTaP/Tdap/Td): _____

Physician Verification

The elevation of the campsite is 6,600 feet. Typical camp activities include ropes course, hiking, archery, horseback riding, rock climbing, boating, yoga, sports, small animal handling, zip-line, swimming, canoeing, etc.

Is patient restricted from any activities? ☐**YES** ☐**NO** ***Does patient have elevation restrictions?*** ☐**YES** ☐**NO**

If yes, please list restrictions: _____

_____

I have been informed of the camp activities and have examined _____, who is physically able to engage in all activities, except as noted above. I hereby verify that all information provided on this form is true and correct.

Physician Name (please print):

Physician Signature: ⊗ **Date:** ⊗

Hospital Affiliation: Address:

Office Phone: On Call/Off Hours:

ATTENTION:

*Don't forget to **date** and **sign** this page. The physical must be performed within a year prior to camp! Thank you!

The Laurel Foundation
75 South Grand Avenue, Pasadena, CA 91105
Phone: (626) 683-0800 Fax: (626) 683-0890

There are two: ⊗