Camp Laurel Physical Form

(To be completed by a licensed physician, nurse practitioner, or physician assistant.)

Physical Information

Camper Name: _____ Height: _____ Weight:_____

Allergies: _____

Please 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)" _____

TB Screening (Required for all campers and must be within 12 months of camp date.)		**Blood Test** *HIV+ campers only, please provide most recent results*
PPD Skin Test **Date:** _____ **Result:** _____	**If camper has a history of past PPD (+):** Date of (+) result: _____ Result of screen CXR: _____ Dates of treatment: _____ Please endorse that camper is currently asymptomatic and poses no infectious TB Risk Physician's Initials: _____	**Date:** _____ Hgb/Hct: _____ Platelets: _____ ANC: _____ CD4/%:_____ Viral Load: _____

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. This physical must be performed within a year prior to camp. Thank you!