

The Laurel Foundation Physical Form

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

Physical Information

Camper Name: _____ Height: _____ Weight: _____

Allergies: Yes No If yes please list below.

Past Medical History _____

Medications taken (prescribed): _____

Please check whether the patient has the following:

	Yes	No		Yes	No		Yes	No
Recent Hospitalizations	___	___	Communicable Diseases	___	___	Seizures	___	___
Neurologic Deficit	___	___	Physical Disabilities	___	___	History of Anaphylaxis	___	___
Hearing/Vision Deficit	___	___	Asthma	___	___			

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

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:	___	___	_____

Immunization History

Varicella: ___ Yes ___ No. Date: _____ If not vaccinated, has patient had Varicella or Zoster?
 Tetanus: ___ Yes ___ No. Date of most recent Tetanus Vaccine/Booster (DTaP/Tdap/Td) _____
 COVID 19. ___ Yes ___ No. Date of Vaccine: Dose 1: _____ Dose 2: _____ Booster: _____

TB Screening

(Required for all campers and must be within 12 months of camp date (6 months if HIV+))

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: _____

Blood Test

HIV+ campers only, please provide most recent results

Date: _____
 Hgb/Hct: _____
 Platelets: _____
 ANC: _____
 CD4/ Count: _____
 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!