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!

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