

# Physical Examination

Physical Exams Are Valid For 3 years  
From Date of Last Examination

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Guardian \_\_\_\_\_ Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

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**TO BE COMPLETED BY A LICENSED PHYSICIAN**

**Date of physical examination:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **B.P.:** \_\_\_\_\_

\_\_\_\_\_ May participate in all camp activities

\_\_\_\_\_ May participate except for: \_\_\_\_\_

Medical information pertinent to routine care and emergencies: \_\_\_\_\_

Does this individual have any significant medical problems? (If so, describe): \_\_\_\_\_

Is there any chronic/recurring illness? \_\_\_\_\_

Is this individual taking prescription medication? YES  NO

If yes, indicate prescription: \_\_\_\_\_

**If this individual will need to take medication while at camp, the Authorization for the Administration of Medication Form, located on the reverse side of this physical must be completed. By state law, we cannot accept nor a camper possess on their person any medication without the completed above named form.**

Does the individual have allergies? YES  NO  plain: \_\_\_\_\_

This individual is up to date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory on Immunization Practices:

<i>Immunization</i>	<i>Date</i>	<i>Immunization</i>	<i>Date</i>	<i>Immunization</i>	<i>Date</i>
Measles	_____	Mumps	_____	Rubella	_____
Chickenpox	_____	Hepatitis B	_____	Polio	_____
Diphtheria	_____	Pertussis	_____		

\_\_\_\_\_ TB (type/result) \_\_\_\_\_ Most recent tetanus date: \_\_\_\_\_

Comments: \_\_\_\_\_

*The above named person is in satisfactory condition & may engage in all camp activities. The following medications are approved for use in first aid treatment of this person except as noted above: Phisoderm, Zephiran, Caladryl lotion, baking soda, meat tenderizer, hydrogen peroxide, aromatic ammonia, lotrimin, tylenol, and bacitracin.*

Date: \_\_\_\_\_ Examining physician's signature: \_\_\_\_\_

Print physician's name: \_\_\_\_\_

State physician licensed in: \_\_\_\_\_ Physician license number: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Complete this form, and return to:

**INDIAN ROCK NATURE PRESERVE, 501 WOLCOTT RD., BRISTOL, CT 06010.**

***Be sure to return completed health form prior to the start of camp. Campers without complete Health and Permission Forms are not permitted to attend Camp.***