MDA Summer Camp

MDA SUMMER CAMP PRE-CAMP PHYSICAL

This section is to be completed by the volunteer's primary care physician, or other primary medical professional, and is used to determine if the applicant is eligible to volunteer at MDA summer camp. This evaluation must take place in the twelve months prior to the camp session.

Volunteer's Name: _____ Age: _____

Vital Signs: Height: _____ Weight: _____ Pulse: _____

Blood Pressure (Resting, Sitting): _____

Resp. Rate (resting): _____

General Inspection: _____

	STATUS, ESSENTIAL FINDINGS, DEVIATING FROM NORMAL
Head	
Eyes/Vision	
Nose	
Mouth/Teeth	
Ears/Hearing	
Neck/Thyroid	
Thorax/Lungs	
Heart	
Abdomen/Hernia	
Skin	
Lymphatics	
Spine	
Extremities	
Emotional Status	

NOTE TO HEALTH PROVIDER:

The above named person wishes to participate as a volunteer at the Muscular Dystrophy Association Summer Camp. Participation involves group living and activities in an outdoor setting, a high level of physical activity, swimming, and attending to the needs of individuals with serious and often life-threatening neuromuscular diseases. At a limited number of camps, camp participants may be exposed to high altitude.

1. **In your medical opinion, is MDA camp an appropriate environment for this individual?**
   ☐ YES ☐ NO *(CHOOSE ONE)*

I have examined the person herein described and have reviewed his/her health history.

2. **Is it your opinion that the applicant is medically, physically and emotionally able to participate as a volunteer at the MDA Summer Camp, which includes a high level of physical activity -- including lifting and caring for individuals affected by a neuromuscular disorder?**
   ☐ YES ☐ NO *(CHOOSE ONE)*

If no, please explain: _____

A PHYSICIAN/HEALTH PROFESSIONAL MUST SIGN AND DATE IN THE SPACES PROVIDED BELOW:

Physician/Medical Professional's Name (Please Print) _____ Address _____

Physician/Medical Professional's Signature _____ City State Zip _____

Date _____ ( ) Phone # _____