DOCTOR'S MEDICAL EXAM FORM

TO BE COMPLETED BY CAMPER'S PRIMARY CARE LICENSED PHYSICIAN OR NURSE

PLEASE SEND THIS TO Barbara *BEFORE CAMP* (bchase@nnec.org)

Physical examination SHOULD BE PERFORMED **not more than 12 months before camp begins**

Camper Name_____ **Age**_____ **Gender M F**

Weight _____ **Height** _____ **Blood Pressure** _____ **Diagnosis** _____

List Restrictions, if any _____

Immunizations: Camp Lawroweld urges each camper to make sure that all immunizations are up-to-date

Vaccines	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
Diptheria, tetanus, pertussis (DTaP or TdaP)						
Tetanus booster (dT) or TdaP) **MUST have had within the past 10 years!**						
Polio (IPV)						
Hepatitis B						
Variella (Chicken pox)						
Mumps measles, rubella (MMR)						
Had chicken pox? Y/N Date:						

Special Considerations/Medical Notes: (Please list all medications, any restrictions, health problems, recent injuries, etc.)

Please list any over-thecounter medications camper/staff cannot take.

VISUAL ACUITY (Required)

Corrected with glasses Left 20/_____ Right 20/___ If either of the camper's eyes are better than 20/200 with glasses, why are they considered legally blind?_____

I have examined the person named herein described and have reviewed his/her health history. It is my opinion that he/she is able to physically engage in camp activities except as noted above.

Physician Office Name: _____

Physician's Address: _____

Physician's Signature: _____ Date: _____

Print Name: _____ Telephone: _____