

**-PHYSICAL EXAMS ARE REQUIRED FOR RESIDENT CAMP PROGRAMS THAT GO OFF-SITE, HAVE INTENSE HIGH ADVENTURE-PROGRAMMING, OR ARE 2 WEEKS OR LONGER IN LENGTH OR A TRIPPING PROGRAM 3 NIGHTS OR LONGER. (HW.5.1)**  
**-RESIDENT CAMP PHYSICAL EXAMS NEED TO BE UPLOADED TO THE ONLINE HEALTH CARE RECORD SYSTEM PROFILE.**  
**-PHYSICAL EXAMS MUST BE COMPLETED WITHIN 24 MONTHS OF THE PROGRAM START DATE. (HW.5.2)**



# Physical Exam Form (HW.5.1)

Locations: _____	Program Date: _____
Program Name: _____	

**Physical Examination:** Required for participants attending certain resident camp programs or a Girl Scouts of Utah sponsored trip (aka. Short-Term Camp) that is three nights or longer i.e. Winter Camping at Cloud Rim. Form needs to be completed by a licensed physician, nurse practitioner, or physician's assistant. **PLEASE KEEP A COPY FOR YOUR RECORDS.**

**PARTICIPANT INFORMATION**

Participant Name: \_\_\_\_\_ Date of Examination: \_\_\_\_\_

**HEALTH EXAMINATION:**

Height: \_\_\_\_\_ Eyes (without glasses/contacts): R 20/\_\_\_ L 20/\_\_\_  
 Weight: \_\_\_\_\_ Eyes (with glasses/contacts): R 20/\_\_\_ L 20/\_\_\_

Blood Pressure: \_\_\_\_\_

Abdomen	Satisfactory	Not Satisfactory	Not Examined
Appearance/Nutrition	Satisfactory	Not Satisfactory	Not Examined
Ears	Satisfactory	Not Satisfactory	Not Examined
General Physical & Emotional Status	Satisfactory	Not Satisfactory	Not Examined
Hair	No Lice	Lice	Not Examined
Hearth	Satisfactory	Not Satisfactory	Not Examined
Lungs	Satisfactory	Not Satisfactory	Not Examined
Musculoskeletal	Satisfactory	Not Satisfactory	Not Examined
Nose	Satisfactory	Not Satisfactory	Not Examined
Skin	Satisfactory	Not Satisfactory	Not Examined
Teeth	Satisfactory	Not Satisfactory	Not Examined
Throat	Satisfactory	Not Satisfactory	Not Examined

HGB*	Satisfactory	Not Satisfactory	Not Examined
Urinalysis*	Satisfactory	Not Satisfactory	Not Examined

*\* Not required for every health exam. A girl 11-18 should have this test if she has not had it since entering puberty*

**SPECIAL DIETARY NEEDS:**

	Circle One		EPI-PEN		Specific Information About Dietary Need	Physician's Initials
Gluten-Free	Allergy	Intolerance	Yes	No		
Lactose-Free	Allergy	Intolerance	Yes	No		
Nuts	Allergy	Intolerance	Yes	No		
Other	Allergy	Intolerance	Yes	No		

\* Please note that the camp will help accommodate food allergies. We recommend families bring their own food in order to help supplement medical dietary needs. Contact the Camp Director for more information (info@gsutah.org).

**PHYSICIAN'S COMMENTS AND RECOMMENDATIONS:**

Give details or indicate management or significant of illnesses.

Does this person have <b>asthma</b> ?	Yes	No
If so, do they have an <b>inhaler</b> they'll be bringing to this event?	Yes	No
Does this person have any <b>allergies</b> (outside of food allergies)?	Yes	No
If so, does this person carry an <b>EPI-pen</b> for any of their allergies?	Yes	No
If so, what is the allergy and what are the <b>symptoms</b> associated with it?		
Does this person have <b>diabetes</b> ?	Yes	No
If so, are they able to <b>manage</b> their diabetes on their own?	Yes	No
This person has a condition which may <b>limit activity</b> for this event?	Yes	No
Does this person have any <b>chronic disease</b> ?	Yes	No
If <b>overweight</b> , will condition <b>restrict activity</b> ?	Yes	No
Does this person have any <b>condition</b> which might <b>limit participation</b> in <b>swimming, hiking, living at high altitude or other strenuous activities</b> ?	Yes	No

**PHYSICIAN'S INFORMATION AND AUTHORIZATION TO PARTICIPATE**

Form needs to be completed by a licensed physician, nurse practitioner, or physician's assistant.

This person is in satisfactory condition and may engage in all usual activities except as noted.

Licensed physician's name:	
Licensed physician's signature	
Address:	
City:	
State:	
Zip Code:	
Phone:	
Date:	

HEALTH FORMS ARE CONSIDERED A PART OF THE PERMANENT CAMP RECORD AND WILL NOT BE RETURNED.