Camp Millhouse

CAMPER PHYSICAL FORM

TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER (M.D., N.P., P.A., D.O.)

Camper's Name: _____ Date of Exam: _____
History of reaction to food, serum, drugs or medications? ____ Yes ____ No
Explain: _____
Sex: _____ Age: _____ Height: _____ Weight: _____ B/P:_____ Pulse: _____ Resp_____
Visual Impairment? Yes ____ No_____
Hearing: Right normal? Yes_____ No_____ Left normal? Yes _____ No _____
Impairment: _____

Immunization History:
Date (month/year) of most recent tetanus shot: _____
Has patient completed the immunizations that were required for school attendance? ☐ Yes ☐ No
Has patient had the COVID vaccine? ☐ Yes ☐ No Manufacturer (Pfizer, Moderna, J&J): _____
Date (month/year) #1: _____ Date (month/year) #2: _____

System	Satisfactory	Unsatisfactory	Describe Abnormalities
Skin, Lymphatic			
Eyes			
Ears			
Mouth			
Nose, throat			
Neck, thyroid			
Chest, breasts, lungs			
Heart rate/rhythm			
Heart murmur (describe)			
Abdomen, liver, kidneys, spleen			
Extremities (back, spine)			
Joints			
Neurological			
Psychological			

Current Diagnosis(ses): _____
_____
The following abnormalities should be noted: _____
_____
The camper: _____does _____does not, have a history of emotional, psychological or psychiatric disturbance.
_____
Applicant may participate in camp activities: ____ with restriction ____ without restriction
Camper should not participate in sports. Reason for limiting activity: _____

Please note: All Camp Millhouse activities are modified for each camper's individual abilities.

*****PLEASE COMPLETE OTHER SIDE*****

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The following non-prescription medications may be stocked in the camp Health Center and are used on an as-needed basis to manage illness and injury. ***__Please cross out those medications the camper should NOT be given.***__

Acetaminophen/Tylenol
Benadryl
Chloroseptic Throat Spray
Cough Drops
Imodium
Ibuprofen/Advil
Tums
Milk of Magnesia
Robitussion/Guaifenesin
Sudafed PE/Phenylephrine
Aloe Gel/Lotion
Triple Antibiotic Ointment
Bandaid Antiseptic Wash
Hydrocortisone Ointment
Calamine Lotion
DEET-Free Insect Repellent
Sunscreen
Tinactin
Artificial Tears

Health Care Provider (please print):
Name: _____
Address: _____
Phone: _____

Signature of Physician: _____ Date: _____
(Original signature required-no stamps)

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