Physician's Approval Form

Camper's Full Name: _____ Birthdate: _____

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

Resting Resp. Rate: _____ Blood Pressure: _____ Temperature: _____

General Inspection: _____

_____

Physical Examination STATUS, ESSENTIAL FINDINGS DEVIATING FROM NORMAL:

Head		Abdomen/ Hernia	
Eyes/ Vision		Skin	
Nose		Lymphatics	
Mouth/ Teeth		Spine/ Ortho	
Ears/ Hearing		Extremities	
Throat/ Thyroid		Emotional State	
Thorax/ Lungs		Neurologic Exam	
Heart		Other	

Recommendations and/ or Restrictions while at camp: Participation involves group living, high levels of physical activity in an outdoor setting, swimming, and possible exposure to extreme climate conditions.

Cardiac		Therapies	
Pulmonary		Swimming	
Special Diet		Strenuous Activity	
Allergies		Horseback Riding	

Immunization History: Please include the last date, and results. Is individual fully immunized? _____Yes _____ No

MMR		Hepatitis B	
DPT, DT, Tdap		Varicella	
Polio		Meningococcal	

Current medications to date: Medication changes will be allowed at camp, as long as in bottle with original prescription.

_____

_____

NOTE TO HEALTH PROVIDERS

1. The above named person wishes to participate as a camper at overnight camp, offered by FOCUS in partnership with Camp Twin Lakes. In your medical opinion, is this camp an appropriate environment for this individual? _____ Yes _____ No
2. I have examined the person herein described and have reviewed his/her health history. Is it your opinion that the applicant is medically able to engage in outdoor camp activities except as noted above? _____ Yes _____ No
3. All overnight campers must be in good health, with no signs of communicable disease or infection and no open or draining wounds. In your medical opinion, does this camper fulfill these eligibility requirements? _____ Yes _____ No

If no to any of the above, please explain: _____

_____

Physician/ Health Professional must complete following:

_____ _____

Physician/Medical Professional's Name (please print) Address

_____ _____ _____

Physician/Medical Professional's Signature Date of Exam Phone