



CIT's Physician's Report

Name: _____ Age: _____ Sex: _____

Address: _____

Home Phone Number: _____

Cell Phone Number: _____

Mother's Name: _____ Mother's cell #: _____

Father's Name: _____ Father's cell #: _____

EMERGENCY CONTACT #1

Name: _____ Relationship: _____

Address: _____

Home Phone Number: _____

Cell Phone Number: _____

Business Phone Number: _____

EMERGENCY CONTACT #2

Name: _____ Relationship: _____

Address: _____

Home Phone Number: _____

Cell Phone Number: _____

Business Phone Number: _____

Personal Health Care Information

Health Care Provider: _____

Group/Identification Number: _____

Phone Number: _____

Primary Physician's Information

Name: _____

Address: _____

Phone Number: _____

Emergency Medical Information (Check all that apply and please explain further)

___ Allergy to a medicine, food, plant, animal or insect toxin
If so, please specify: _____

___ Any condition that may require special care, medication or diet
If so, please specify: _____

___ ADHD (*Attention Deficit Hyperactive Disorder*)

___ Asthma

___ Convulsions
If so, please explain: _____

___ Heart trouble/Hypertension
If so, please explain: _____

___ Diabetes

___ Contact Lenses

___ Fainting Spells
If so, please explain: _____

___ Bleeding Disorders
If so, please specify: _____

If there is any other medical concern that we should be aware of that is not mentioned in the above list, please explain below: _____

THE FOLLOWING INFORMATION SHOULD BE COMPLETED BY YOUR PHYSICIAN.

Date of your most recent physical: _____

Height _____ **Weight** _____ **B/P** _____ **Pulse** _____

Vision (Please check any that apply): **Normal** _____ **Glasses** _____ **Contacts** _____

Hearing: Normal _____ **Abnormal** _____

Check if normal; Circle if abnormal and give details below:

____ Growth, development	____ Teeth, tonsils	____ Genitourinary
____ Skin, glands, hair	____ Respiratory	____ Musculoskeletal
____ Head, neck, thyroid	____ Cardiovascular	____ Neuropsychiatric
____ Eyes, ears, nose	____ Abdomen, hernia	____ Other (specify)

Comments: _____

IMMUNIZATIONS

Tetanus Immunization Date: _____

If the patient has had any of the following, please indicate the year affected.

____ DPT/OPV ____ Measles ____ Mumps ____ Rubella ____ Hepatitis B ____ Chicken Pox

Are there any current physical, mental, or psychological conditions requiring medication treatment or special restrictions or conditions while at camp?

Please circle one: No Yes (please explain): _____

Are there any restrictions in the staff member's ability to participate in camp activities?

Please circle one: No Yes (please explain): _____

Are there any conditions which health center staff will have to supervise?

Please circle one: No Yes (please explain): _____

Date This Form Was Completed: _____

Health Care Provider's Signature: _____