Staff 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: ____