

# **CAMP ODAYIN CAMPER PHYSICAL EXAM FORM**

(To be filled out by your primary care physician, not a cardiologist)

All campers are required to have a physical exam within one year of the first day they will attend camp.  
Dear Doctor: In order to attend Camp Odayin, campers must be recommended to Camp Odayin by their cardiologist and approved by our Medical Director. Please provide us additional health information after performing a physical examination.

Camper Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female

Parent / Guardian Name: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Heart rate \_\_\_\_\_

Special Health Conditions (check all that apply and explain below)

- |   |  |
|---|--|
| <input type="checkbox"/> Arthritis                                  | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Attention Deficit / Hyperactivity Disorder | <input type="checkbox"/> Autism/Asperger's     |
| <input type="checkbox"/> Behavioral or Developmental Problems       | <input type="checkbox"/> Cerebral Palsy        |
| <input type="checkbox"/> Cystic Fibrosis                            | <input type="checkbox"/> Dental Problems       |
| <input type="checkbox"/> Diabetes                                   | <input type="checkbox"/> Encopresis            |
| <input type="checkbox"/> Enuresis                                   | <input type="checkbox"/> Head or Spinal Injury |
| <input type="checkbox"/> Hearing Impairment                         | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Muscular Dystrophy                         | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Sickle Cell Disease                        | <input type="checkbox"/> Spina Bifida          |
| <input type="checkbox"/> Visual Impairment                          | <input type="checkbox"/> Other: _____          |

**Immunization history:** Tetanus Booster \_\_\_/\_\_\_/\_\_\_ Polio Series \_\_\_/\_\_\_/\_\_\_  
(please provide dates) Measles \_\_\_/\_\_\_/\_\_\_ Mumps \_\_\_/\_\_\_/\_\_\_  
DPT series \_\_\_/\_\_\_/\_\_\_ Chicken Pox \_\_\_/\_\_\_/\_\_\_

Please list non-cardiac surgeries / medical procedures and dates performed:  
\_\_\_\_\_  
\_\_\_\_\_

Treatments to be continued at camp:  
\_\_\_\_\_  
\_\_\_\_\_

Description of any limitations or restrictions while at camp:  
\_\_\_\_\_  
\_\_\_\_\_

Additional information for medical staff at camp:  
\_\_\_\_\_  
\_\_\_\_\_

Physician Signature \_\_\_\_\_ (print name) \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

**This form must be completed and signed by a physician, physician's assistant, or nurse practitioner, and returned to the camp office. **Must be stamped by the clinic.** Thank you.**

**Due by May 1st – Residential Campers**      **Due by July 1st – Day Campers**