

CAMP ODAYIN CAMPER PHYSICAL EXAM FORM

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

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.

Deadlines: MN Residential Camper due May 1, WI Residential Camper due June 1, MN Day Campers due July 1

All campers are required to have a physical exam within one year of the first day they will attend camp.

Camper Name: _____ Birth date: _____
Date of last physical exam: _____ Gender: ___ Male ___ Female
Home Address: _____
Parent / Guardian Name: _____ Home Phone: _____
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:

Clinic Stamp:

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

Signature Date

Name, printed Phone