PART 3: SAC MEDICAL EXAMINATION FORM

To be completed and signed by *a licensed physician*. The examination must be completed by an approved *medical professional* within 24 months of arriving at camp

Camper Name			**Date of Physical:**	
Today's Date:			**DOB:**	Age:
Height:	Weight:	Blood pressure:	Pulse:	LMP:
Head		Lungs		**Code:** **S- Satisfactory** **X-Not Satisfactory** **O-Not Examined**
Nose		Extremities		
Throat		Abdomen		
Ears		Posture (spine)		
Eyes		Hernia		

ALLERGIES:
○ No known allergies
○ To foods (List)
○ To Medications (list)
○ To Environment (list)
○ Other (list)
Describe Previous Reactions:

NUTRITIAN/DIET
○ Normal Diet
○ Has Restrictions: (List)

THE CAMPER IS UNDERGOING TREATMENT AT THIS TIME FOR THE FOLLOWING CONDITIONS:
○ None
○ Is undergoing treatment at this time. Please describe:

DO YOU FEEL THE CAMPER WILL REQUIRE LIMITATIONS OR RESTRICTIONS TO ACTIVITY WHILE AT CAMP?
○ No Restrictions
○ Will be Restricted. Please describe below:

I have examined the individual and have reviewed their health history. It is my opinion that they are physically able to engage in camp activities except as noted above. I have been this applicant's health provider for _______ years.

Signature of Examining Physician: ____ Printed Name: ______________________________ Date:__/___/___

Office Address:____ Phone: __________________________

IMMUNIZATION HISTORY

*Starred immunizations must be current. Copies of forms from health care providers or state or local government are acceptable. Please attach.

Campers Name: ______________________________________

Immunization	**Dose 1 Month/YR**	**Dose 2 Month/YR**	**Dose 3 MontH/YR**	**Dose 4 Month/YR**	**Dose 5 Month/YR**	**MOST RECENT DOSE MONTH/YR**
Diptheria, Tetanus, Pertussis (DTaP)*						
Tetanus Booster (Td or Tdap)*						
Mumps Measles Rubella (MMR)*						
Polio (IPV)*						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ○ Had disease Date:						
Meningococcal meningitis(MCV4) Recommended not required						
Rotavirus (Recommended not required)						
Gardasil (Recommended not required)						
Tuberculosis (TB) test	Date: ○ Negative ○ Positive					