Easterseals Camp Forms—Physical Examination

All campers must have the Physical Examination completed & signed by a licensed physician, PA or CRNP *OR* an equivalent form that was completed within 12 months of the camp date.

Your physical must be returned 2 weeks before the start of camp by uploading it to your profile *or*

E-MAIL: asilcox@eastersealswcpenna.org **FAX:** 717-741-5359 **MAIL:** ESWCPA, 2550 Kingston Road, Suite 219, York, PA 17402

Camper Name: _____ **Date of Birth:**_____/_____/_____ **Sex: M or F**

Immunization History - Please record the most recent date (month and year) of the following immunizations or attached an immunization record for the camper.

_____ **DTP**	_____ **IPV**	_____ **Hep B**
_____ **DTP/Hib**	_____ **MMR**	_____ **HIB**
_____ **DTaP**	_____ **Measles**	_____ **Varicella**
_____ **DT/Td**	_____ **Mumps**	_____ **PCV**
_____ **OPV**	_____ **Rubella**	_____ **Meningitis**

Health History - (check all that apply)

____ **Bleeding/clotting disorders**
____ **Frequent Ear Infections**
____ **Heart defects/disease**
____ **Seizures (type/frequency)**
____ **Asthma**
____ **Diabetes**
____ **Fainting**

Please describe all that are checked: _____

_____

_____

_____

Height: _____ Weight: _____ Blood Pressure: _____

The camper is under the care of a physician for the following condition(s):_____

_____

Current treatment (including medications): _____

_____

Any treatments to be continued at camp? _____

_____

Surgeries or serious injuries (date): _____

Allergies (food, drug, plant, animal, etc.): _____

_____

Any recommended restrictions while at camp?: _____

_____

Additional Health Information: _____

_____

_____

Physician Consent and Signature: I have examined the person listed above and have reviewed the health history. It is my opinion that this camper is capable of engaging in camp activities, except as noted above.

Signature: _____ **Date:** _____

Print Name: _____ **Office Phone:** _____

Address: _____ **Emergency Phone:** _____

City, State, Zip _____