Camper Name_______________

CAMP POINT CLEAR PHYSICIAN'S FORM P.1

This person is in satisfactory condition and may engage in all activities except those noted.

Physician's Name____________________Signature___________________

Address_________________City______________State________Zip_____

Camper Name____DOB___________Parent's or Guardian's Name_____________________________________ Home Address___________________City_________State_____Zip____

Home Phone_____________________ Mother's Cell_________________ Father's Cell__________________________ Emergency Contact ________________ Phone__________

IMMUNIZATIONS Year Primary Series Completed

D.T.P. _______________ Diptheria __________ Tetanus_________ Whooping Cough__________ Oral Polio _______________ Measles _______________ Smallpox _______________ Mumps _______________ Other (Rubella)______

TB Test ______________ Year of Last Booster ______________

Health History__Chicken Pox__ Measles__ German Measles __ Mumps

Physician's Form P. 2

(**check**) **Allergies**__Hay Fever__Asthma__Insect Sting__Food

List Foods_____________ __Poison Ivy, Oak, etc

____Ear Infection __Heart Disease __Convulsions __Diabetes __Behavior __Headaches

Other (Please Explain)____

Date Of last Examination_____________ Height______ Weight____

Appearance-Nutrition_________

Code: Satisfactory (S) Not Satisfactory (NS) Ears__Throat__Nose__ Musculoskeletal___ Heart__Teeth__ Abdomen__ Lungs__ Skin__ Urinalysis__

Other Notes____

____

Operation or other serious injuries (Date)____________________________

____

Hospitalizations____

Comments where applicable:

Fainting__________ Sleep Disturbances_______________________

Bed Wetting____

Menstruation_________________ Constipation_________________

Specific Activities to be restricted _____________________________

____