CAMP BEAUSITE NORTHWEST PHYSICAL EXAMINATION FORM

***THIS FORM MUST BE COMPLETED, SIGNED AND RETURNED BY LICENSED MEDICAL PROVIDER, TO BE RECEIVED BY CAMP BEAUSITE BY JUNE 1. Information must be current (within 12 months of attending camp.)**

Part I: Personal Information (completed by parent/guardian)

Campers Name: ______________________________________ Nickname: _________________

Male ______ Female______ DOB: ___/___/_____ Current age: _______________

Address: ____
Street City State Zip

Custodial Parent/Guardian: __________________________Phone: ________________________
Email address: ______________________________________

Emergency Contact: ________________________________Phone:________________________ *
The emergency contact must be someone who can be easily reached at all times.

Part II: Medical information (to be completed by healthcare provider)

Height _______ Weight _______ BP _______ HR _______ Resp ______ Temp _______

Assessment: Skin/scalp _____________________ Eyes ______________ Ears _______________
Nose, throat and mouth ____________________________ Teeth and gums _________________
Glands (thyroid, etc) ______________________________ Chest/lungs______________________
Heart___________________________________ Abdomen _____________________________
GU_____________________________________

Allergies: ________Latex ________________________Insect stings ____________________

Food Allergy (List):___________________________

Environmental ____
Medication ____

If the individual has an allergy, what reaction (s) does he/she have?
____
____

Does this individual have a prescription for a rescue inhaler? ____Yes ____ No

Does this individual have/carry a prescription for an Epi-Pen? ____ Yes _____ No

Does this individual have a seizure disorder/history of seizures? ___ Yes ___ No

If yes, please describe type and frequency of seizures (what do they look like?) and preferred intervention/treatment:____
____
____
_____________________________________ Date of last seizure________________________

Vaccinations: Current on all vaccinations except: ________________________

Hepatitis B series? ___Y ___N Date of last Tetanus vaccine _________

TB test/Date read __/__/__ Pos or Neg

Medications: Is this individual on any prescribed medications? ___Yes ___ No

Is this individual approved for OTC medications on a prn basis? ___Yes ___No

If yes to either question above, you will also need to complete and return the Medication Authorization Form (see web site). This form must be signed by a licensed practitioner in order for the camper to be given medications of any kind, including herbal and OTC medications.

Medical treatments to be continued at camp:
____
____

Chronic medical conditions: ____
____
____

Medically prescribed meal plan or dietary restrictions:
____
____

Camp activities include archery, swimming, horseback riding, nature walks, outdoor games & activities. Are there restrictions on any of these activities? ______________________________
____

____

Additional information for our nursing
staff:____
____
____
____
____
____

I have examined the above named individual and reviewed his/her health history. It is my opinion that he/she is physically able to engage in any required activities, except as noted above, and is free of communicable or contagious disease

Signature of licensed physician/medical provider ________________________________
Date___/___/___

Printed name of Physician/Medical Provider ___________________________________

Phone #_______________________

Please mail to:

Camp Beausite NW

P.O. Box 1227

Port Hadlock, WA 98339

Questions? Contact Director of Programs 360-808-5629 or 360-732-7222