Camp Beausite Northwest

2020 Physical Examination Form

This form MUST be filled out by a medical provider and returned prior to attending camp.

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

Camper's Name: ____ Nickname: ______________________

Male: ______ Female: ______ DOB: _____ /_____ / __________ Current age: ________

Address: ____ 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: ____

____

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Chronic medical conditions: ____

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____

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?

____

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____

Additional information for our nursing staff: ____

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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 Physician/Medical Provider: ____ Date: __________

Printed name of Physician/Medical Provider: ____

Phone #: _________________________

Please mail to: Camp Beausite Northwest or E-mail to: programs@campbeausitenw.org
P.O. Box 1227
Port Hadlock, WA 98339

Questions? Contact our office 360-732-7222