2020 Camp Grizzly Youth Leadership Camp
PHYSICAL EXAMINATION & HISTORY FORM

(Please Print):
Full Name of Applicant:_____ Date of Exam:_____

Birth Date:_____ Gender: M_____F_____ Hair Color_____ Eye Color _____

Height:_____ Weight:_____ Blood Pressure:_____ Temperature: _____

GENERAL QUESTIONS ON HEALTH HISTORY:

Frequent Ear Infection	____Yes	____No	Asthma	____ Yes	____ No
Cardiovascular Disorders	____Yes	____No	Chicken Pox	____ Yes	____ No
Epilepsy/Seizures	____Yes	____No	Measles	____ Yes	____ No
Diabetes	____Yes	____No	Meningitis	____ Yes	____ No
Bleeding Disorders	____Yes	____No	Autism/Aspergers	____ Yes	____ No
ADD/ADHD	____Yes	____No	Hepatitis (A,B,C)	____ Yes	____ No
Have a history of bed-wetting?	____Yes	____No	Skin (Rash, etc.)	____ Yes	____ No
Ever had an eating disorder?	____ Yes	____No	Other:_____		

Have seen a mental health professional? ____ Yes ____ No
Please explain any "yes" answers above: _____
Ever had surgery ? If yes, provide dates:_____
Ever been hospitalized? Provide dates:_____
Loss of consciousness, convulsions or concussion? _____
Any recent injury, illness, or infectious diseases?_____
Please provide information about the child's behavior and physical/emotional well-being that would assist the camp:
_____

Does your child require a special diet?: [ ] Vegetarian [ ] Gluten Free [ ] Religious/Cultural [ ] Diabetic [ ] Other

Please describe: _____

ALLERGIES: [ ] Food:_____ [ ] Drug:_____

Please describe the allergy reaction and management:_____

MEDICATIONS: Please list all medications to be continued while at camp. All medications are secured by and administered by the Camp Nurse only.

Name of Prescription:	Dosage:	Specific times taken:	Reason:

[ ] My child does not take regular medication

IMMUNIZATION REPORT: (Please record the specific date (month/year) of the most recent booster doses for Tetanus.)

Vaccine: Tetanus (DPT/ TD/ T):	Date of Last Booster:	Tuberculosis (TB) Vaccine Date:	Skin Test Result: [ ] Negative [ ] Positive [ ] Chest Xray

ARE ALL IMMUNIZATIONS CURRENT?_____YES _____NO ****YOU MUST ATTACH A COPY OF UPDATED IMMUNIZATION RECORD****

****NOTE: Your child will be checked for head lice and any type of contagious fungus (ie: ringworm, etc.) or fever. Your child <u>will not</u> be admitted to camp with these conditions per Camp Health Policy and Regulations and no refund will be given.**

<u>To be completed by child's physician</u>:
I have examined the camp applicant named above. In my opinion, the applicant's current health condition [ ] ***does*** [ ]***does not*** preclude his/her participation in an active camp program. The applicant is under my care for the following condition and/or treatment:

_____

Signature of Licensed Medical Personnel:_____

Print Name:_____ Date:_____

Street Address:_____City:_____ State:_____Zip Code:_____

Daytime Phone:_____ Fax number: _____