

**SECTION NINE \*\*\*Camper Health Record & Examination Form**

This section is to be completed by the camper's primary care physician or other medical professional. This evaluation must take place no more than three months just prior to the camp session and more recently if the camper's health so requires.

Camper's Name \_\_\_\_\_

Vital Signs: Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse \_\_\_\_\_

Resp. Rate (resting): \_\_\_\_\_ Blood Pressure (Resting, Sitting): \_\_\_\_\_

General Inspection/Type of Neuromuscular Disease: \_\_\_\_\_

	Normal	Essential Findings, Deviating From Normal
Head		
Eyes/Vision		
Nose		
Mouth/Teeth		
Ears/Hearing		
Neck/Thyroid		
Thorax/Lungs		
Heart		
Abdomen/Hernia		
Skin		
Lymphatics		
Spine		
Extremities		

Neurologic Exam: \_\_\_\_\_

**RECOMMENDATIONS AND/OR RESTRICTIONS WHILE AT CAMP**

Special Diet \_\_\_\_\_

Special Medication (please specify) \_\_\_\_\_

Therapy (respiratory) \_\_\_\_\_

Swimming \_\_\_\_\_

Strenuous Activity \_\_\_\_\_

Other \_\_\_\_\_

Does patient present with dependant edema? YES  NO  If Yes, any restrictions?

**NOTE TO HEALTH PROVIDER:** The above named person wishes to participate as a camper at the Volunteers Assisting the Disabled Summer Camp. Participation involves being outdoors, a minimal level of physical activity, and swimming. I have examined the person herein described and have reviewed his/her health history. It is my opinion that the applicant is medically able to engage in camp activities, except as noted above.

YES  NO  Date: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Physician/Medical Professional's Name (Please Print) \_\_\_\_\_ Address \_\_\_\_\_

Physician/Medical Professional's Signature \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_