Summer Camp at Civitan
MEDICAL FORM

Note: you do not have to use this form if you have a physical within the past year. Your Physician may send us the copy of the completed physical.

Please complete this form in its entirety. It is extremely important. The form must be completed by the applicant's regular physician based upon an examination that has taken place not greater than one year prior to the session starting date, and it must be received in our office no later than 30 days prior to the first day of the session the camper is attending. *After this date the applicant's reservation may be voided and filled by an applicant on the waiting list.*

NOTE TO PHYSICIAN: *The information requested in this form is extremely important to the applicant's health and safety during participation in our vacation and respite services at Civitan. In most cases the level of activity will be higher than normal and the daily routine will be different. Camp may have visiting nurse; however, we are able to provide only routine, basic health care. It is crucial that care be taken in thoroughly completing this form in the event that an emergency situation should arise. Thank you for your assistance in this important matter.*

*****Please attach a copy of a record of immunizations.*****

APPLICANT'S NAME: _____ **SEX**: ☐ Male ☐ Female

DATE OF BIRTH: _____ **Height**_____ **Weight**_____ **Blood Pressure**_____

PRIMARY DIAGNOSIS: (please be specific) _____

Functional disabilities_____

Any communicable diseases: ☐ Yes ☐ No *If Yes, give name and treatment*_____

DOES APPLICANT HAVE ANY LIFE THREATENING ALLERGIES? ☐ Yes ☐ No

TO WHAT: ☐ Bee sting or insect bite ☐ Pollen ☐ Serum ☐ Other _____

☐ **Food** (***Be specific***)_____

☐ **Drugs** (penicillin,etc.)_____ ☐ Other_____

Signs of allergic reaction _____

Recommended treatment _____

Please list any activities in which applicant may *NOT* participate or attach precautions or special instructions for routine camp activities:_____

_____

eggleston

Summer Camp at Civitan
Medical Form (continued)

Applicant's Name_____ **Last Tetanus shot date:** _____

Please examine the following areas:

	Normal	Abnormal (describe)		Normal	Abnormal (describe)
Eyes			Cardio-Vascular		
Ears			Respiratory		
Nose			Abdominal		
Throat / Mouth			Neurological		
Skin			Musculoskeletal		

Check if applicant has had any of the following and list treatment needed:

☐ Bleeding/Clotting disorders_____ ☐ Frequent Urinary Tract Infections

☐ Frequent ear infections_____ ☐ Diabetes_____

☐ Heart defect disease_____ ☐ Shunt_____

Has applicant been hospitalized in the past year? ☐ YES ☐ NO reason:_____

Has applicant ever required any psychiatric treatment/counseling or hospitalization?

☐ YES ☐ NO if *yes Date/reason:* _____

I have examined the above named individual and certify that they are in satisfactory physical condition, free from any contagious or infectious disease and capable of active participation in the regular vacation/respite program.

Signature of Physician completing physical: _____

Doctor's Name (Print)_____ **Date of Examination:** _____

Address _____

City _____ **State**_____ **Zip**_____

Phone:_____ **Fax:** _____