



2017 PHYSICAL EXAM RECORD

To be filled out by your licensed physician. You must have a physical examination within 12 months of the session start date. Keep a copy of this completed form for your records.

Physicians, please complete and return to guardian.

Deadline: APRIL 15, 2017

All camper information is to be uploaded and/or entered in CampDoc's – please contact us if you have questions
Ph: 715.385.2312 • Fax: 715.385.2461
camp@manito-wish.org



SUMMER CAMP & OUTPOST

TO THE EXAMINING PHYSICIAN: Camp Manito-wish YMCA is a resident summer camp in Boulder Junction, WI. All staff and campers are required to be physically active, and participate on canoeing, sea kayaking, and/or backpacking trips of varying lengths. Physical activity may include:
• **Strenuous activities during hot weather** • **Carrying heavy packs and /or canoes** • **Walking on uneven terrain**
It is important to the safety and well-being of all participants that we obtain accurate information regarding this person's current medical status and medical history.

Name	Camper's name	First		Middle in.	Last				
	Please check the session(s) your child is attending.								
Summer Camp	BOYS	<input type="checkbox"/>	2-week session 1 (June 14 – June 27)		GIRLS	<input type="checkbox"/>	2-week session 1 (July 15 – July 28)		
	Summer Camp	<input type="checkbox"/>	2-week session 2 (June 29 – July 12)		Summer Camp	<input type="checkbox"/>	2-week session 2 (July 30 – Aug 12)		
	Sessions:	<input type="checkbox"/>	4-week session (June 14– July 12)		Sessions:	<input type="checkbox"/>	4-week session (July 15 – Aug 12)		
Outpost	Please check (x) the Level, Trip Type and Session (where applicable) your child is attending.								
	Level:	<input type="checkbox"/>	Voyageur	<input type="checkbox"/>	Intermediate	<input type="checkbox"/>	Advanced	<input type="checkbox"/>	Expeditionary
	Trip Type:	<input type="checkbox"/>	Canoeing	<input type="checkbox"/>	Backpacking	<input type="checkbox"/>	Sea Kayaking	<input type="checkbox"/>	
	Session:	<input type="checkbox"/>	Session 1	<input type="checkbox"/>	Session 2	<input type="checkbox"/>			

Vaccines	You may send a copy of medical office record. Required immunizations must be determined locally. Please record the date (month/year) of basic immunizations and most recent booster doses.					
	Vaccines			Date of Basic Immunization		Booster Dose
	Diphtheria			1.		1.
	Pertussis (Whooping Cough)	OR	DPT/DTaP	2.		2.
	Tetanus			3.		
	Tetanus	OR	TD			
	Diphtheria					
	Injectable Polio (Salk)					
	Oral Polio (Sabin) TOPV					
	Tetanus					
	Measles, Mumps, Rubella (MMR)					
	Pneumococcus (Pevnar)					
Hepatitis B (HBV)						
Hemophilus Influenza type B (HIB)						
Meningococcus						
Other						

Allergies	Examples: Medications, insect stings, environmental, food		
	Allergy (list below)	Reaction	Medication

Instructions	Physician's notes. If the participant has diabetes or anaphylactic reactions, please provide complete treatment information.

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Physical Examination by Licensed Physician	Code: S = satisfactory NS = not satisfactory (explain) O = not examined			
	Height	Weight:	B.P.:	Hct Or Hgb Test:
	Eyes	Hernia	Allergy:	
	Glasses	Extremities		
	Ears	Including:		
	Nose	Shoulder		
	Throat	Knees	General Appraisal:	
	Heart	Ankles		
	Genitalia	Feet		
	Lungs	Posture/spine		
	Abdomen	Skin		

Females	Has she menstruated?	If not, has she been educated about menstruation?
	If so, is her menstrual history normal?	Special considerations:

Restrictions	Recommendations/Restrictions while in Camp	
	Special diet	
	Current medications	
	Strenuous activity	
	Other	

Medications	Prescriptions MUST be in original containers. Please send only prescription medications that your child is currently using. If an over the counter medication is prescribed, include sufficient amount for camper's session in original container. **The Health Center will only administer medications for which information is completed below				
	Medication	Dosage	Frequency (# days)	Route	If PRN, indicate reason:
	If participant is on psychiatric medications, how long have they been on their current medication routine (dose/frequency?)				
	If a change has been made in the last three months, please give more information:				

Physician Approval	Physician's signature REQUIRED. On the basis of your knowledge of the applicant, the applicant's medical history, the present physical examination of the applicant and your knowledge of the activities in which they will be asked to participate, do you feel this individual is able to participate in the Camp Manito-wish program?			YES	NO
	Physician's signature:		Date:		
	Physician name (print):				
	Complete address:				
	Phone:		Email:		