

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, 2019

All camper information is to be uploaded and/or entered in CampDoc's – please contact us if you have questions
Ph: 715.385.2312 • 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 and cold weather** • **Carrying heavy packs and /or canoes** • **Walking on uneven terrain.**

Camp Manito-wish YMCA is not a rehabilitation program. CMY is not a place to work through behavioral or psychological problems.

Prior physical conditioning and enthusiastic mental attitude are a necessity. Participants find CMY's outpost program to be an extremely demanding experience both physically and emotionally.

Camp Manito-wish YMCA courses are wilderness expeditions, varying in length from eight days to three months. Expeditions operate in remote areas where evacuations to modern medical facilities may take days.

Outpost participants 14 and older may experience:

- **Extreme weather conditions** with temperatures ranging from -40°F. to +100° F.; prolonged storms, high winds, intense sunlight, sudden immersion in cold water and/or high seas are possible
- **Physical demands on the participants** may include carrying a backpack weighing between 55-85 pounds over uneven terrain such as snow, rocks, boulders, fallen logs, or slippery surfaces as well as ascending or descending steep mountain slopes
- **Elevations for backpacking courses** range from sea level to 12,000 feet; Peak climbs and mountain courses may be as high as 14,000 feet
- **Physical demands of sea kayaking and river courses** require paddling heavily loaded kayaks, canoes and lifting and carrying boats over uneven terrain

It is extremely 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	<input type="checkbox"/> Summer Camp (select one) <input type="checkbox"/> Outpost
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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	OR	DPT/DTaP	1.	1.
	Pertussis (Whooping Cough)			2.	2.
	Tetanus			3.	
	Tetanus	OR	TD		
	Diphtheria				
	Injectable Polio (Salk)				
	Oral Polio (Sabin) TOPV				
	Tetanus				
	Measles, Mumps, Rubella (MMR)				
	Pneumococcus (Pnevnar)				
Hepatitis B (HBV)					
Hemophilus Influenza type B (HIB)					
Meningococcus					
Other					

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

Notes	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:		