2023 Staff Physical Examination Record

Staff Member's Name_____

PHYSICAL EXAM POLICY:

*You must have a **physical exam within 12 months of the employment start date***

TO THE EXAMINING PHYSICIAN: We need your help! 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 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 this and other participants that we obtain accurate information regarding this person's current medical status and medical history.

IMMUNIZATION: (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**
Diphtheria Pertussis (Whooping Cough) DPT/DTaP Tetanus or	1. 2. 3.	1. 2.
Tetanus TD Diphtheria or		
Injectable Polio (Salk)		
Oral Polio (Sabin) TOPV		
Tetanus		
Measles, Mumps, Rubella, or MMR		
Pneumococcus (Prevnar)		
Hepatitis B (HBV)		
Hemophilus Influenza type B (HIB)		
Meningococcus		
COVID-19		
Other		

STAFF ONLY: **Tuberculin test given**_____ **Administer Mantoux**_____ **neg/pos Chest x-ray if nec.**_____
(Must be within 12 months of start date for Staff) DATE_____ DATE_____

Have you been out of the country? Y / N If yes, where? _____ Date of Return to States_____

ALLERGIES: (For example: Medications, Insect Stings, Environmental, Food)

Allergy (list below)	**Reaction**	**Medication Required**

PHYSICIAN'S PROGRESS NOTE OR SPECIAL INSTRUCTIONS:

_____

_____

_____

_____

****If the participant has diabetes or anaphylactic reactions, please be sure to provide complete treatment information.**

Revised 3/2021

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Staff Member's Name_____

(To be filled out by licensed physician)

Code: S – Satisfactory, NS - Not Satisfactory (explain), O - Not Examined

Height_____ Weight_____ B.P. _____ Hct. or Hgb. Test_____

Eyes _____
Glasses_____
Ears _____
Nose _____
Throat _____
Heart _____
Genitalia _____
Lungs _____
Abdomen_____

Hernia _____
Extremities _____
Including:
Shoulder_____
Knees_____
Ankles_____
Feet_____
Posture (Spine) _____
Skin_____

ALLERGY:
_____
_____
_____

GENERAL APPRAISAL:
_____
_____
_____

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

Recommendations and restrictions while in camp:

Special Diet _____
Current Medications _____
Strenuous Activity _____
High Risk Factors for contracting Covid-19_____
Other _____

TO EXAMINING PHYSICIAN: Please list all Physician Orders for medication or treatment, including vitamins and Homeopathic treatments.

MEDICATION

Medication	Dosage	Freq (# days)	route	if prn - indicate reason

TREATMENTS _____
_____

If medications are listed above, will they affect the individual's ability to perform camp job duties? YES NO
If yes, please provide explanation _____
_____

If participant is on psychiatric medications; for how long have they been on their current medication routine? (Dose and frequency)_____

If a change has been made in that last three months, please give more information. _____
_____
_____

PHYSICIAN'S SIGNATURE REQUIRED:

On the basis of your knowledge of the applicant, the applicant's medical history, the present physical examination of this 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**_____

Name of Physician (Please Print):_____

Complete Address: _____

Telephone: ( ) _____ Email: _____