2025 Staff Physical Examination Record

Staff Member's Name_____

PHYSICAL EXAM POLICY:

*You must have a **physical exam within 24 months of the employment start date***

TO THE EXAMINING LICENSED INDEPENDENT PROVIDER (MD/DO/NP/PA): We need your help! Camp Manito-wish YMCA is a resident summer camp in Boulder Junction, WI with a focus on overnight camping in the wilderness. 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		

Have you ever been diagnosed with <u>active</u> TB? Y / N **Have you ever been diagnosed with <u>latent</u> TB?** Y / N
Have you ever had a positive TB skin test or TB blood test? Y / N
Have you ever been treated with medication for TB or for a positive TB test (eg, taken "INH")? Y / N

If the answers to any of these questions is "Yes", then please provide documentation about the treatment and results.

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, anaphylactic reactions, or other chronic conditions, please be sure to provide complete treatment information.**

Revised: Apr 24, 2025

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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	_____	Hernia	_____	Skin:	_____
Glasses	_____	Extremities	_____	Gastro-Intestinal:	_____
Ears	_____	Including:		Kidney:	_____
Nose	_____	Shoulder	_____	GENERAL APPRAISAL:	
Throat	_____	Knees	_____	_____	
Heart	_____	Ankles	_____	_____	
Genitalia	_____	Feet	_____	_____	
Lungs	_____	Posture (Spine)	_____	_____	
Abdomen	_____	Neck	_____	_____	

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 _____
Other _____

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

MEDICATION

Medication	Dosage	Freq (# days)	Route	Timing or other notes

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 mental health 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 Licensed Independent Provider(Please Print):_____

Complete Address: _____

Telephone: ( ) _____ Email: _____

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