



# 2026 Physical Examination Form

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: \_\_\_\_\_