Easterseals Oregon /Evans Creek Retreat/B'nai B'rith Camp
Physical Exam Form

Camper Name: _____ **Date of Appointment:** _____

This form is to be completed by a licensed physician, nurse practitioner, or physician's assistant. A medical examination must be completed within twelve (12) months of participation in camp session. Physicians may provide their own standardized form.

Height	_____	Weight	_____	Temp	_____
EENT	_____	Lungs	_____	Pulse	_____
Heart	_____	Abdomen	_____	Resp.	_____
GU	_____	Blood Press.	_____		

State the approximate date of occurrence or most recent incident:

□ Chicken pox	_____	□ Mumps	_____	□ **Allergies**	
□ Diabetes	_____	□ Ear infections	_____	□ Latex	_____
□ Rheumatic Fever	_____	□ Asthma	_____	□ Foodallergy	_____
□ Measles	_____	□ Rescue inhaler		□ Insectstings	_____
□ Hepatitis carrier	_____	□ Seizures	_____	□ Penicillin	_____
□ Migraines	_____	□ Shunt	_____	□ Other:	_____
□ Sunburn-prone	_____	□ Other:	_____		

If the applicant has an allergy, what reaction(s) does he/she have?

Does this person have a positive diagnostic x-ray for an Atlantoaxial Dislocation Condition? **YES NO**

The applicant is under the care of a physician for the following medical diagnosis/disability: (Describe any operations of serious illnesses that relate to the participant's condition or care.)

_____

_____

Vaccinations

Current on all childhood vaccinations except: _____

Date of most recent Tetanus vaccine: _____ TB Test read: _____ ☐ Positive ☐ Negative

Recommendations & Restrictions for Easterseals Recreational Programs:

In my opinion, the above conditions permits the applicant's participation in an active recreational program. **(Circle) Yes NO**

There are medical reasons for limiting and/or restricting swimming, horseback riding, boating, or sleeping in tents:

(Circle) Yes NO Limitations are:

_____

Treatments and diets that are to be continued while participating in Easterseals Oregon's camping program are:

_____

I have examined the person herein described and reviewed his/her health history. It is my opinion that he/she is physically able to engage in any required activities, except as may be noted above, and is free of communicable or contagious disease.

Signature of licensed practitioner: _____ Date: _____

Printed Name: _____ Phone Number: _____

Mail completed form to:
Easterseals Oregon Camp Coordinator | 7300 SW Hunziker Rd, Suite 103, Portland, OR 97223
Fax: 503.228.1352 | Phone: 503.228.5108