



2024 Easterseals Oregon Evans Creek Retreat 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:

- | | | |
|--------------------------------------------------|-----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Chicken pox _____ | <input type="checkbox"/> Mumps _____ | Allergies |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Ear infections _____ | <input type="checkbox"/> Latex _____ |
| <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Food allergy _____ |
| <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Rescue inhaler _____ | <input type="checkbox"/> Insect stings _____ |
| <input type="checkbox"/> Hepatitis carrier _____ | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Penicillin _____ |
| <input type="checkbox"/> Migraines _____ | <input type="checkbox"/> Shunt _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Sunburn-prone _____ | <input type="checkbox"/> 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 noted above, and is free of communicable or contagious disease.

Signature of licensed practitioner: _____ Date: _____

Printed Name: _____ Phone Number: _____

Mail completed form too:

Easterseals Oregon Camp Admin| 7300 SW Hunziker Rd, Suite 103, Portland, OR 97223
Fax: 503.228.1352 | Phone: 503.228.5108 | camp@or.easterseals.com

Or:

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