# Physical Examination Form



Easterseals Camp Stand by Me
P.O. Box 289
Vaughn, WA 98394
253-884-2722 (Main) / 253-590-0594 (Fax)

**Please scan and email this document to campadmin@wa.easterseals.com or Fax to 253-590-0594.**

Campers must have a physical exam no more than 12 months prior to the session they are attending.

Please turn this form in no later than 30 days prior to a summer session the camper is attending, or 2 weeks prior to a respite session.

## Parent/Guardian Fill-in Section

Camper's Name: _____

Birth Date: _____

Primary Disability: _____

Does Camper take medication? *(Circle choice)*

- Yes
- No

☐ I attest that all immunizations are up to date.

☐ My camper has an exemption for immunizations.

Parent/Guardian Name: _____

Signature: _____

**Parent / Guardian: Please stop here. The rest of this form is to be completed by medical personnel.**

**Today's date: _____**

**Physical exam done today? (*Circle choice*) Yes No (If "No", date of last physical exam _____)**

**NOTE: *ACA accreditation standards specify physical exam must be within the last 12 months.***

**Height _____ Weight _____ Temp _____ BP _____ HR _____ RR _____**

**Significant Health History**

_____

_____

**Allergies**

**Please note allergy and reactions.**

- **To foods (list): _____**
- **To medications (list) _____**
- **To the environment (insect stings, hay fever, etc. (list):_____**
- **Other allergies (List): _____**
- **No known allergies**

**Diet/Nutrition**

- **Eats a regular diet**
- **Has a medically prescribed meal plan or dietary restrictions (describe below):**

_____

_____

**Seizures**

- **Yes (If "Yes", last seizure date): _____**
- **No**

**Describe seizure (type & frequency):**

_____

_____

 Camper's Name: _____ Birth Date: _____

**Diabetes**
- **Yes (if "Yes", type and treatment):** _____
- **No**

**Heart Condition**
- **Yes (if "Yes", type and treatment):** _____
- **No**

**Date of Most Recent Tetanus Shot:** _____

**Asthma**
- **Yes (if "Yes", type and treatment):** _____
- **No**

**Chronic or Recurring Illnesses**
**Describe:**
_____
_____

**Recent Illness or Hospitalization**
**Describe:**
_____
_____

**Pressure Sores or Significant Bruises**
**Describe:**
_____
_____

**Health or Safety Risk to self, other campers, or staff**
**Describe:**
_____
_____

**Special instructions and restrictions to activity while at camp**
**Describe:**
_____
_____

**I have examined _____ and reviewed his/her health history. I have discussed the camp program with the camper's parent(s)/guardian(s) and it is my determination that the camper is fit to participate in camp activities, except where noted otherwise.**

**Examining Physician (please print): _____ Signature:** _____

**Office Address:** _____

**Office Phone:** _____ **Office Fax:** _____

**Date:** _____