

Camp Assignment:  Trefoil Ranch  Camp Cloud Rim  Other \_\_\_\_\_

Program Title \_\_\_\_\_ Session Date \_\_\_\_\_

**THIS FORM MUST BE RETURNED TO GSU, PO BOX 57280, SALT LAKE CITY, UT 84157  
BY MAY 14 IF YOU ARE ATTENDING CAMP CLOUD RIM OR TREFOIL RANCH**



## PHYSICAL EXAM FORM

*This form is for camps or trips three nights or longer*

This form must be completed by a licensed physician, nurse practitioner, physician's assistant or registered nurse.  
MUST be completed within the last 24 months of camp session attended.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Health Examination:

Height \_\_\_\_\_ Weight \_\_\_\_\_ B.P. \_\_\_\_\_

Appearance-Nutrition \_\_\_\_\_

Without Glasses \_\_\_\_\_ With Glasses \_\_\_\_\_

Eyes R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_

Ears \_\_\_\_\_ Hearing R \_\_\_\_\_ L \_\_\_\_\_

Code: Satisfactory=S

Not satisfactory=NS

Not examined =NE

Nose \_\_\_\_\_ Throat \_\_\_\_\_

Teeth \_\_\_\_\_ Heart \_\_\_\_\_

Lungs \_\_\_\_\_ Abdomen \_\_\_\_\_

Skin \_\_\_\_\_ Head/hair (no lice) \_\_\_\_\_

Musculoskeletal \_\_\_\_\_

General physical and emotional status \_\_\_\_\_

Urinalysis\* \_\_\_\_\_ HGB\* \_\_\_\_\_

\*Not required for every health exam. A girl 11-18 should have this test if she has not had it since entering puberty.

Other notes:

Physician's comments and recommendations.

Give details or indicate management or significant illnesses.

- Does person have any condition which might limit activity for this event?  Yes  No
- Does person have any chronic disease?  Yes  No
- If overweight, will condition restrict activity?  Yes  No
- Does person have any condition which might limit her/his participation in swimming, hiking, living at high altitude or other strenuous activities?  Yes  No

### Record of Immunization:

Immunization	Year Primary Series Completed	Year of Last Booster
DtaP	_____	_____
Diphtheria	_____	_____
Pertussis (Whooping Cough)	_____	_____
Tetanus (within last 10 years)	_____	_____
Td	_____	_____
Oral polio/IPV	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
HiB	_____	_____
Hep B	_____	_____
Tuberculin test Yr. Last given <u>s</u>	_____	Result _____
Other	_____	_____
Typhoid and Paratyphoid	_____	_____
Cholera	_____	_____
Yellow Fever	_____	_____
Typhus	_____	_____
Rocky Mountain Spotted Fever	_____	_____

This person is in satisfactory condition and may engage in all usual activities except as noted.

Licensed physician's name:

\_\_\_\_\_

Licensed physician's signature:

\_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Date \_\_\_\_\_

**Health Forms are considered part of the permanent camp record and cannot be returned**