

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 13 IF YOU ARE ATTENDING CAMP**



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