Make Running Fun Cross Country Camp

Physical Form

This form must be filled out and signed by a doctor. If the athlete has had a physical during this past school year, a copy of that physical signed by a doctor may be submitted instead. The physical must be done within one calendar year of the last day of camp.

Athlete's Name ______________________________ **Date of Exam** ____________

Ht. ________ Wt. ________ Pulse __________ BP ____________T ________ Resp. __________

Date of last TB Mantoux Test __________ Result ______________________________

If positive, date of chest x-ray __________ Result ______________________________

Head ______________________________ Heart ______________________________

Eyes ______________________________ Breasts ______________________________

Vision ______________ Corrected ____________ Abdomen ______________________________

Ears ______________________________ GYN ______________________________

Nose ______________________________ Lymphatics ______________________________

Mouth & throat ______________________________ Extremities ______________________________

Neck ______________________________ Neurological ______________________________

Chest ______________________________ Skin ______________________________

CBC Date ____________ Result ______________________________

Urinalysis Date ____________ Result ______________________________

PRESCRIPTIONS: Please list all medications, **prescription and over-the-counter**, to be taken at camp, **even those only taken on an "as needed" basis.** A note on prescriptions: nurses can only administer prescription medication that has been packages by a licensed pharmacist that identifies the prescribing physician, dosage, frequency and route of administration.
Nurses cannot administer medications, prescription or over-the-counter, unless the physician signs below.

Name of Medication Frequency and Dosage Reason for Taking

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OVER-THE-COUNTER MEDICATION (OTC): Camp physicians may prescribe OTC medication such as Tylenol, Claritin and cortisone crème. List any restrictions on OTC and non-prescription medication.

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Indicate **ALL** medications taken during the school year the camper **WILL NOT** be taking at camp.

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Licensed Medical Personnel Authorization: I have reviewed this form in its entirety. The health history and physical exam is complete and the camp participant has permission to engage in all camp activities **except as noted above.**

Print Name ______________________ Signature ______________________ Date ________

License # ____________ Address ______________________________ Phone __________

Reviewed / screened by camp health care provider: ______________________________
(Name) (Signature) (Date)