Location of Program ❑ Camp Anna Behrens ❑ Camp Sakakawea
Program Date: ____________ Program Name:____________

# Physical Examination

Physical Examination: Required for participants attending a camp/trip, that is three nights or longer. Form needs to be completed by a licensed physician, nurse practitioner, physician's assistant or registered nurse. Completed within 12 months of program the participant is attending.
**PLEASE KEEP A COPY FOR YOUR RECORDS.**

Health History: Separate document. Required for participants attending resident camp, troop camping at resident camp, and extended troop trips lasting three nights or longer.

Medication Log: Separate document. To be completed if participant is bringing prescription medications to program.

If attending a resident camp program, mail this completed form by June 6th to:

Girl Scouts of Michigan Shore to Shore
Attention: Camp Forms
3275 Walker Ave NW
Grand Rapids, MI 49544

If registering for resident camp program after June 6th mail completed form to above address at least two weeks prior to your camper's session.

**PARTICIPANT INFORMATION**

Participant Name:____________________________________ Date of Examination:______________________________

**HEALTH EXAMINATION:**

Height: ________Weight: _________B.P._____ Appearance/Nutrition:______

Without Glasses With Glasses
Eyes: R 20/______L20/_______ R 20/______L20/______Hearing R ____L___

Code: Satisfactory (S)
Not Satisfactory (NS)
Not examined (NE)

Ears:______ 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

**RECORDS OF IMMUNIZATIONS:**
(You may include a copy of your Michigan School Immunization Record)

| Immunization | Primary Series (Yr.) | Last Booster (Yr) |
|---|---|---|
| DTP. Dtap.DT, Tb | ________________ | _____________ |
| HiB | ________________ | _____________ |
| Polio (IPV or OPV) | ________________ | _____________ |
| _MMR | ________________ | _____________ |
| _Measles | ________________ | _____________ |
| _Mumps | ________________ | _____________ |
| _Rubella | ________________ | _____________ |
| _Hepatitis B (HBV) | ________________ | _____________ |
| _Varicella (Chicken pox) | ________________ | _____________ |
| _Typhoid & Paratyphoid | ________________ | _____________ |
| _Cholera | ________________ | _____________ |
| _Yellow Fever | ________________ | _____________ |
| _Typhus | ________________ | _____________ |
| _Rocky Mtn Spot Fever | ________________ | _____________ |
| Tuberculin Test: Last Date | ________________ Result | _____________ |

**PHYSICANA'S COMMENTS AND RECOMMENDATIONS:**
Give details or indicate management or significant of illnesses.

This person has a condition which may limit activity for this event? ❑Yes ❑ No

Does this person have any chronic disease? ❑Yes ❑ No

If overweight, will condition restrict activity? ❑Yes ❑ No

Does this person have any condition which might limit her/his participation in swimming, hiking or any strenuous activities? ❑Yes ❑ No

**PHYSICAN'S INFORMATION AND AUTHORIZATION TO PARTICIATE**
This person is in satisfactory condition and may engage in all usual activities except as noted.

Licensed physicians name:________________________________________

Licensed physicians' signature:_____________________________________

Address:_____________________________________________________

City:______________________ State:____ Zip Code:_________________

Phone:_____________________ Date:____________________________

**HEALTH FORMS ARE CONSIDERED A PART OF THE PERMANENT CAMP RECORD AND WILL NOT BE RETURNED.**