THE WILLOW SCHOOL **Willow in the Woods Summer Camp**

SUMMER CAMP HEALTH AND PHYSICAL EXAM FORM (Age 3 to Rising Grade 4 Only)

Student's Name: _____ **Birth Date:** _____
Sex: ☐ **Male** ☐ **Female** **Immunization Registry Number:** _____

DISEASE HISTORY	TYPE/ YEAR	DISEASE HISTORY	TYPE/YEAR
Food Allergies		Mononucleosis	
Non-Food, non-drug allergies		Neuromuscular Disorder	
Asthma		Chronic Otitis Media	
Congenital Disorder		Autoimmune Disorder	
Convulsive Disorder		Strep Infections	
Diabetes		Juvenile Rheumatoid Arthritis	
Influenza		Autism Spectrum Disorder	
Other		Hematological Disorder	
Drug Allergies		ADD/ADHD	
Heart Disease		Concussion/TBI	
Chicken Pox		Vision Disorder	
Hepatitis		Hearing Disorder	
Lyme Disease			

OPERATION/INJURIES (PLEASE SPECIFY):

1.
2.
3.

ADDITIONAL COMMENTS:

IMMUNIZATIONS: PLEASE ATTACH CAMPER'S VACCINE RECORD

Influenza: Required for Pre-School only
Tdap and Meningococcal: Required for entrance into 6th grade

Mantoux (PPD)	**Date administered:**	**Date Read and Results:**	**Vaccine, BCG date**
IGRA			

MEDICATIONS: _____

***** Kindly provide medication order if medication is required during school hours**

1. **ALLERGIES** (Drug/Environmental/Food):
   _____
2. **Camper Requires Epinephrine: ____Yes ____ No ***A medication order & 2 EpiPens are needed for camp** _____
3. **Camper Requires Rescue Inhaler:____ Yes ____ No *** A medication order and an inhaler are needed for camp. Please consider allowing 5th through 8th grade students to self-administer.**

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Student name **Date of Exam**

Height:	Weight:	Pulse:	B/P:
Vision: Uncorrected	Right:	Left:	
Vision: Corrected	Right:	Left:	
Hearing Screen:	Right:	Left:	

	Normal Exam	**Abnormal Findings:**
Head		
Eyes		
Ears		
Nose		
Throat		
Lymph Glands		
Heart		
Lungs		
Abdomen		
Hernia		
Genitalia		
Skin		
Orthopedic		
Scoliosis		
Neurological		
Speech		
Nutrition		

Any Limitation of Activity? : □ No □ Yes (Please define):

_____

_____

Physician's Comments and Recommendations:

_____

_____

Physician's signature: _____ **Date:** _____

Physician's Name, Address and Telephone #:

_____

_____

_____

_____