Project Kindle Camper Physical Form

(TO BE COMPLETED AND SIGNED BY YOUR CHILD’S DOCTOR OR NURSE PRACTITIONER)

**General Information:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_ Age at Camp \_\_\_\_\_

Allergies/reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender  Male  Female

General Physician/Provider Information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (On-call contact) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Exam:**

Please list any pertinent physical findings or attach a recent H & P.

Height: \_\_\_\_\_\_\_\_\_\_\_\_ BP: \_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Pulse: \_\_\_\_\_\_\_\_\_

BMI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temp: \_\_\_\_\_\_\_\_\_

WNL ABNL

\_\_\_\_\_ \_\_\_\_\_ H.E.E.N.T. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ Neuro \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ Abdomen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ Hearing/Vision \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ Genitalia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ Resp \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ Cardio\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ Musculoskeletal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ Integ\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunization History:**

**REQUIRED: Is this child medically stable and able to fly in a non-pressurized aircraft?**

**> > YES NO < <**

**Please attach most current documentation of immunizations, including all childhood series, childhood boosters and adult boosters.**

**IMMUNIZATIONS MUST BE PROVIDED BEFORE CHILD CAN PARTICIPATE IN CAMP ACTIVITIES.**

Date of last TB Mantoux Test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pos/Neg\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If Positive*, follow-up tests performed and results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discuss any recent infections or ongoing limitations:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does this child have:

Blood sugar monitoring? Yes \_\_ No \_\_ Insulin? Yes\_\_ No\_\_

If diabetic, last Hgb A1c\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE ATTATCH A PHOTO COPY OF BOTH SIDES OF CAMPERS MEDICAID OR INSURANCE CARD**

G-tube? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, for meds?\_\_\_\_ Tube Feeding?\_\_\_\_

Nebulizer treatments? Yes \_\_\_\_\_ No \_\_\_\_\_ Scheduled?\_\_\_\_\_ PRN?\_\_\_\_\_

IV or injectable (SQ, IM) medications? Yes \_\_\_\_ No \_\_\_\_\_ If yes, please explain below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Laboratory Data for Children with HIV/AIDS only:**  DATE OF TEST: \_\_\_\_\_\_\_\_\_\_ Viral load \_\_\_\_\_\_\_\_\_  WBC \_\_\_\_\_\_\_\_\_\_ CD4 count \_\_\_\_\_\_\_\_\_  RBC \_\_\_\_\_\_\_\_\_\_ CD4 % \_\_\_\_\_\_\_\_\_  Hgb \_\_\_\_\_\_\_\_\_\_ CD8 count \_\_\_\_\_\_\_\_\_  Hct \_\_\_\_\_\_\_\_\_\_ CD8 % \_\_\_\_\_\_\_\_\_  Plt \_\_\_\_\_\_\_\_\_\_ CD4/CD8 ratio \_\_\_\_\_\_\_\_\_  ***If BMP/CMP, lipid panel, liver function or kidney function tests available, please include copies of lab reports (especially if abnormal results).*** |
| Physician Verification  I have examined the above named person herein described and have reviewed the health history. It is my opinion that this child:  \_\_\_\_\_ is physically able to travel to camp (may include commercial or private  non- pressurized airplane) and engage in camp activities.  \_\_\_\_\_ is able to travel to camp, and engage in activities, but has restrictions as follows:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CAMPER IS ABLE TO PARTICIPATE IN SWIMMING POOL ACTIVITIES WHEN OFFERED:  YES NO  (please circle)  **Examining Physician/Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_ | |