

Health Examination by a LICENSED PHYSICIAN

TO THE EXAMINING PHYSICIAN: We need your help! Phantom Lake YMCA Camp is an ACA accredited camp which requires all staff and campers to have a physical within **24 months** of arrival at camp. This form must be fully completed before sending to camp.

CAMPER NAME _____ Date of Birth _____

The above applicant's most current examination was on _____
month day year

Height _____ Weight _____ Blood Pressure _____

The applicant is under my care for the following **conditions**:

Current **treatments** include: _____

Does the applicant have any **SIGNIFICANT HEALTH CONDITIONS**? Please list:

RECOMMENDATIONS AND RESTRICTIONS AT CAMP

Treatment to be continued at camp: *type, frequency, requires licensed health care provider to perform?*

Medications to be administered at camp:

NAME / TYPE	DOSE	ROUTE	FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any medically prescribed meal plan or **dietary restrictions**:

Known **Allergies**:

Description of any **limitation or restriction** on camp activities:

Additional information for health care staff at camp:

Immunization History: *Please fill out the **back page** of this form or attach current Immunization History*

PHYSICIAN'S SIGNATURE _____ **Date of form completion** ___/___/___

****REQUIRED to ATTEND CAMP****

Physician's Printed Name: _____ Title: _____

Address _____

Office Phone: _____ Fax: _____

PLEASE TURN OVER AND FILL OUT IMMUNIZATION HISTORY

Please give all dates of immunizations for:							Which of the following illnesses has the participant had?	
	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr		
DTP	_____	_____	_____	_____	_____	_____	Mumps _____	Date _____
TD (tetan/dipt)	_____	_____	_____	_____	_____	_____	German Measles _____	Date _____
Tetanus	_____	_____	_____	_____	_____	_____	Chicken Pox _____	Date _____
Polio	_____	_____	_____	_____	_____	_____	Measles _____	Date _____
MMR	_____	_____						
Or Measles	_____	_____						
Or Mumps	_____	_____						
Or Rubella	_____	_____						
Date of Last TB (tuberculossis) test	_____							
Haemophilus Influenza B	_____	_____	_____				Results: Positive _____	
Hepatitis B	_____	_____	_____				Negative _____	
Varicella (chicken pox)	_____	_____						

THANK YOU FOR MAILING IN THIS FORM TO:

**PHANTOM LAKE YMCA CAMP
S110W30240 YMCA CAMP RD
MUKWONAGO, WI 53149
Fax # 262-363-4351
Phone:262-363-4386
office@phantomlakeymca.org**