

Camper Physical Examination Report by Licensed Medical Personnel

Waycross Camp 7363 Bear Creek Rd, Morgantown, IN 46160 812-597-4241 www.WaycrossCCC.org

Medical Personnel: Please review the Camper Health History Form and complete the sections below.

Name _____ Date of Birth _____

Examination		
Height:	Weight:	Male Female (circle one)
BP: / (/)	Pulse:	Vision R 20/ L 20/
Corrected: Yes No (circle one)		
Medical	Normal	Abnormal Findings
Appearance <input type="checkbox"/> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart • Murmurs (auscultations standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses <input type="checkbox"/> Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin <input type="checkbox"/> HSV, lesions suggestive of MRSA, tines corporis		
Neurologic		
Musculoskeletal	Normal	Abnormal Findings
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional <input type="checkbox"/> Duck-walk, single leg hop		

_____ Camper Health History reviewed
_____ Cleared for all activities without restrictions
_____ Cleared for all activities with the following restrictions _____

I verify that this health form is complete and accurate to the best of my knowledge and it is on my opinion that this individual is physically and emotionally able to participate in the camp program, except as noted above.

Name of licensed medical professional:	Title:
Signature:	Date:
Office Address:	
Phone:	