

# PHYSICAL HEALTH AND MEDICAL HISTORY

**Beyond Malibu REQUIRES that this page be completed by a physician.**

Name: \_\_\_\_\_

**Health Care Recommendations:**

I have examined the above applicant within the past 12 months. Date Examined \_\_\_\_\_

In my opinion, the above's condition does  does not  preclude his/her participation in an active camp program.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

The applicant is under the care of a physician for the following condition(s) \_\_\_\_\_

Current treatment (Include current medications) \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion or concussion \_\_\_\_\_

Does the applicant have epilepsy?  Yes  No Does the applicant have diabetes?  Yes  No

Health History (Give approximate dates)	Diseases	Allergies (Date not needed)
_____ Frequent Ear Infections	_____ Chicken Pox	_____ Hay Fever
_____ Heart Defect/Disease	_____ Measles	_____ Ivy Poisoning, etc.
_____ Diabetes	_____ German measles	_____ Insect Stings
_____ Bleeding/Clotting Disorder	_____ Mumps	_____ Penicillin
_____ Hypertension		_____ Other Drugs
_____ Mononucleosis		_____ Asthma
_____ Convulsions		_____ Other (Specify) _____

Operations or serious injuries (Dates) \_\_\_\_\_

Chronic or recurring illness or medical condition \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_

Special health and behavioral considerations \_\_\_\_\_

<b>IMMUNIZATION HISTORY:</b> Required immunization will be determined locally. Please record the date (month and year) of basic immunizations and most recent booster shot.		
Vaccines	Year of Basic Immunization	Year of Booster
Diphtheria	1.	
<b>DPT</b> : Pertussis (Whooping Cough)	2.	1.
Tetanus	3.	2.
Tetanus		
<b>TD</b> : Diphtheria		
Oral Polio (Sabin)* TOPV		
Injectable Polio (SALK)		
Measles (Hard measles, Red Measles, Rubeola)		
Other		
Tuberculin test given _____ (Most recent)		
Haemophilus Influenza b (HIB)		
Hepatitis B		

**Recommendations and Restrictions While at Camp**

Any treatment to be continued at camp \_\_\_\_\_

Any medication to be administered at camp (Specific dosages) \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions \_\_\_\_\_

Any allergies (Foods, drugs, plants, insects) \_\_\_\_\_

Activities to be limited \_\_\_\_\_

**Additional health information** \_\_\_\_\_

Licensed Physician's Signature _____  Date of Form completion _____ *By _____ <p style="text-align: right; font-size: small;">* Initial if completed by nurse or physician's assistant</p>
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