GMC PHYSICAL HEALTH EXAMINATION

Exam should be completed within the past 24 months and must be signed for participation.
Confidential Information.

Participant's Name:_____ Age: _____ Date of Birth: _____
(First name, Last name)
GMC Camp Session #s (please list all): _____ GMC Session Dates: _____

TO BE COMPLETED BY LICENSED PHYSICIAN: **Date of Exam:** _____
Height: _____ **Weight:** _____

Check = Normal. If abnormal or notable history, please describe on the line provided.

Medical

- ☐ Appearance_____
- ☐ Skin_____
- ☐ Eyes _____(Corrected vision: ☐ Yes ☐ No)
- ☐ Ears_____
- ☐ Nose_____
- ☐ Dental/Oral_____
- ☐ Heart_____
- ☐ Lungs_____
- ☐ Abdomen_____

Musculoskeletal

- ☐ Neck_____
- ☐ Back_____
- ☐ Shoulder/Arms_____
- ☐ Elbows_____
- ☐ Wrists/Hands/Fingers_____
- ☐ Hips/Legs_____
- ☐ Knees_____
- ☐ Ankles/Feet/Toes_____
- ☐ Other_____

Check yes or no as appropriate.

Yes	No	
☐	☐	Allergies: _____ Allergy Action Plan ☐ Yes ☐ No (If yes, please attach)
☐	☐	Asthma: _____ Asthma Action Plan ☐ Yes ☐ No (If yes, please attach)
☐	☐	Diabetes: _____
☐	☐	Seizure disorder/Epilepsy: _____
☐	☐	Reported loss of consciousness or concussion:_____
☐	☐	Mental illness (including depression, anxiety, eating disorders): _____ _____
☐	☐	Current treatment(s) and/or medication(s): _____ _____
☐	☐	Other conditions(s) that the camp health supervisor or staff should be made aware of:_____ _____ _____

☐ **This participant is <u>fully able to participate</u> in a day or overnight camp program without restriction.**
☐ **This participant is able to participate in a day or overnight camp program with the following restrictions/recommendations:** _____
_____
_____

Licensed Physicians Signature: _____Date: _____
Printed Name _____ Phone Number: _____

Initials if completed by nurse or physician assistant: _____