

Physical Exam for Camp Helen Keller

TO BE COMPLETED BY LICENSED PHYSICIAN

Must be submitted on or before May 1st of current year. Only this form is accepted; NO Substitutions.

Keep a copy for your records.

Examined Name: _____ Gender: M ___ F ___ DOB ___/___/___

Height: _____ Weight _____ Blood Pressure _____ Pulse _____ Respiration _____

Skin Condition: _____

Is this examined person: Please mark which is applicable

Deaf	
Hard of Hearing	
Blind	
Partially sighted	
Both	

Level of hearing Acuity Unaided: Left ear: _____ Right Ear: _____

Does the examined wear: _____ Hearing Aids _____ Cochlear _____ Both

Which ear is the h/a worn: _____ Right _____ Left

Which ear is the Cochlear worn: _____ Right _____ Left

Level of Visual Acuity: Left eye: 20/_____uncorrected Right eye: 20/_____uncorrected

Left eye: 20/_____corrected Right eye: 20/_____corrected

Does the examined wear: Glasses: _____Yes _____No

Contacts: _____Yes _____No

Uses eye drops? _____Yes _____No

The examined person is currently under physician care for the following condition(s):

Current Treatment(s) to continue at camp: _____

Are "Standing Orders" suggested for examined? Yes ___ No ___ If yes, please attach orders.

Medication/Treatments: All medications must be in properly labeled containers

Medication	Dosage	Time Given	Reason for use

Does examined have diabetes? _____Yes _____No Type: _____

Is the examined on Insulin? _____Yes _____No Type: _____Oral _____Inject

Dosage: _____ If IM shots are used can person self-inject? Yes ___ No ___

Any medically prescribed meal plan or diet restrictions _____Yes _____No

If Yes, describe _____

(Physical Exam Camp Helen Keller-PAGE 2 OF 2)

Does the examined have Asthma? Yes ___ No ___ Use an Inhaler? Yes ___ No ___ What Type _____

Should the examined keep inhaler? Yes ___ No ___ OR Inhaler remains in nurse's office? Yes ___ No ___

Does the examined have Cerebral Palsy? Yes ___ No ___

Does the examined have Muscular Dystrophy? Yes ___ No ___

Does the examined have epilepsy/seizure disorder? Yes ___ No ___ If Yes, frequency of seizures _____

On Medication Yes ___ No ___ Describe on set behavior _____

Does the examined have any cognitive/behavioral disabilities? Yes ___ No ___ If yes, please describe: _____

BD ___ ADD ___ LD ___ ADHD ___ Alzheimer's ___ MI ___ Other: _____

Does the examined wear false teeth/partial plate? Yes ___ No ___

Does the examined use a prosthesis? Yes ___ No ___

Does the examined use a Wheelchair ___ Walker ___ Crutches ___ Braces ___ Other _____

Any allergies (food, drugs, plants, insects, etc.)? Yes ___ No ___ If Yes, please describe _____

Current Treatment if allergic reaction occurs: _____

Any additional health information? _____

Activities the examined cannot participate in: _____

Activities to encourage participation in _____

*****IMMUNIZATION HISTORY: MANDATORY TO INCLUDE*****

Tetanus shot for camp (within 10 years) Date last given: ___/___/___

TB Test for camp (within 3 years) Date last given: ___/___/___ Result: _____

Please mark an x by appropriate answer

I have examined the above LIF Helen Keller Camp applicant. In my opinion, the examined applicant is ___ OR is not ___ medically fit to participate in an active camp program.

Licensed Physician's Signature: _____

Address: _____ City _____ State _____

Daytime Phone: _____ Emergency Phone: _____

Email: _____

Date exam completed: ___/___/___ Examined By: _____

Return to:

Lions of Illinois Foundation

Camp Helen Keller

700 N Peace Road, Suite B, DeKalb, IL 60115

camplions@lifnd.org or Fax: 815-748-9087

******* APPLICATION DEADLINE IS MAY 1st*******