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? Y/N

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********