2022 Camp Grizzly Youth Leadership Camp
PHYSICAL EXAMINATION & HISTORY FORM

(Please Print):

Full Name of Applicant:____ Date of Exam:________________________

Birth Date:______________ Gender: M_____F______ Hair Color____________________ Eye Color ____________________

Height:_________________ Weight:_______________ Blood Pressure:_________________ Temperature: ______________

GENERAL QUESTIONS ON HEALTH HISTORY:

Frequent Ear Infection ____Yes ____No
Cardiovascular Disorders ____Yes ____No
Epilepsy/Seizures ____Yes ____No
Diabetes ____Yes ____No
Bleeding Disorders ____Yes ____No
ADD/ADHD ____Yes ____No
Have a history of bed-wetting? ____Yes ____No
Ever had an eating disorder? ____Yes ____No
Have seen a mental health professional? ____Yes ____No

Asthma ____Yes ____No
Chicken Pox ____Yes ____No
Measles ____Yes ____No
Meningitis ____Yes ____No
Autism/Asperger ____Yes ____No
Hepatitis (A,B,C) ____Yes ____No
Skin (Rash, etc.) ____Yes ____No
Other:____________________________

Please explain any "yes" answers above: ____

Ever had surgery ? If yes, provide dates:____

Ever been hospitalized? Provide dates:____

Loss of consciousness, convulsions or concussion? ____

Any recent injury, illness, or infectious diseases?____

Please provide information about the child's behavior and physical/emotional well-being that would assist the camp**:**

____

Does your child require a special diet?: [ ] Vegetarian [ ] Vegan [ ] Religious/Cultural [ ] Diabetic [ ] Gluten Free

Other [ ] **Please describe**: ____

ALLERGIES: [ ] Food:__________________________ [ ] Drug:____

Please describe the allergy reaction and management:____

MEDICATIONS: Please list all medications to be continued while at camp. All medications are secured by and administered by the Camp Nurse only.

Name of Prescription:	Dosage:	Specific times taken:	Reason:

[ ] My child does not take regular medication

IMMUNIZATION REPORT: (Please record the specific date (month/year) of the most recent booster doses for Tetanus and Covid-19.)

Vaccine: Tetanus (DPT /TD/ T)	Date of last Tetanus booster (Month/Year):	Covid-19 Vaccine Date: Month/Year 1st Dose: 2nd Dose:	Date of last Covid booster Month/Year:

ARE ALL OTHER IMMUNIZATIONS CURRENT?_____YES ______NO ****YOU MUST ATTACH A COPY OF UPDATED IMMUNIZATION RECORD****

*****NOTE: Upon camp arrival, your child will be screened for any contagious illness (ie: ringworm, lice etc.) and abnormal temperature. A negative Covid test must be brought within 24 hours of camp arrival/check-in day. Your child will not be admitted with any illness as per Camp Health Policy and Health Code Regulations and no refund will be given.**

To be completed by child's physician:
I have examined the camp applicant named above. In my opinion, the applicant's current health condition ___*does* ___*does not* preclude his/her participation in an active camp program. The applicant is under my care for the following condition and/or treatment:

____

Signature of Licensed Medical Personnel:____

Print Name:____ Date:____

Street Address:________________________________City:_________________________ State:________Zip Code:_____________

Daytime Phone:____ Fax number: ___________________________________