CAMPER PHYSICIAN EXAMINATION FORM

A licensed physician must complete all pages of this form!

Important: This form must be completed and returned to our office no later than June 15, 2022

CAMPER'S INFORMATION

Camper's Name:	Date:
Birthdate:	Gender:

GENERAL PHYSICIAN/PROVIDER INFORMATION

Name:	Office Phone:
Address:	Office Fax:
Emergency On-Call Contact:	

PHYSICAL EXAM

Vitals Signs
Height:
Weight:
BP:
Pulse:
Temp:

	Satisfactory	Not Satisfactory	Not Examined
H.E.E.N.T.			
Neuro			
Hearing/Vision			
Genitalia			
Heart			
Lungs			
Musculoskeletal			
Skin			

IMMUNIZATION HISTORY

or attach a current documentation of immunization record:

Vaccines	Date of Basic Immunization	Date of Last Booster
Diphtheria		
Pertussis (Whooping Cough)		
Tetanus		
Polio		
Measles/Rubella		
Mumps		
Tuberculin test given (most recent)		
Varicella (chicken pox)		
Other		

Does this child have:	YES	NO
Central venous line?		
G-Tube?		
TPN?		
IV or subcutaneous medications?		
If yes, please explain:		

Discuss any recent infections or ongoing limitations:

	YES	NO
Is patient receiving IV immunoglobulin?		
If Yes, how often?		Date of last dose:
Other diseases or details not mentioned above:		

CURRENT MEDICATIONS

Drug Name	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

PSYCHOSOCIAL INFORMATION

Pertinent Psychosocial Information:

If you are aware of anyone who can provide us with pertinent psychosocial information to help us give the best possible services to this child, please list name and contact information here.

Name:	Phone:
Name:	Phone:

COGNITIVE DEVELOPMENTAL

Cognitive Development Level: (Select One) ☐ Age Appropriate ☐ Mild Delay ☐ Moderate Delay ☐ Severe Delay
Comments:

I M P O R T A N T

Please notify Camp Sunburst if camper is exposed to any communicable disease during the three weeks prior to camp attendance. (chicken pox, measles, flu, lice or bed bugs, etc.)

If this child experiences any significant changes in health status after filling out this form (i.e., significant illness, hospitalization, change in medication, consultation with specialist, etc.) PLEASE notify Camp Sunburst prior to the child's arrival at camp.

PHYSICIAN VERIFICATION

I have examined the above-named person herein described and have reviewed their health history.

It is my opinion that this child:

☐ ***IS*** *physically able to travel to camp (may include commercial airline) and engage in camp activities.*

☐ ***IS*** *able to travel to camp, and engage in activities, but has restrictions as follows:*

Restrictions:

*Camper **IS** able to participate in swimming pool activities when offered:* ☐ YES ☐ NO

Please Read Carefully Before Signing

Physician's Statement: *I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.*

	Date:
Examining Physician Signature	
PLEASE, Print Name	
Address	Phone

Please return this completed form to:

Sunburst Projects, 2143 Hurley Way, Suite 240 Sacramento CA, 95825

or fax to: 916 440-1208 or email: admin@sunburstprojects.org

For questions: (530) 401-3576