

2019 FIREFIGHTERS KIDS CAMP

CAMPER - MEDICAL EXAMINATION REPORT



LAST FIRST MI BIRTH DATE

INSURANCE PROVIDER POLICY # PHYSICIAN NAME PHONE #

HEALTH HISTORY TO BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT OR ADVANCED PRACTICE NURSE

The purpose of the examination is to determine the camper's ability to participate in basic activities, has a communicable disease that could be conveyed to others or has a medical, physical or emotional condition that would require special attention by the camp staff.

	YES	NO		YES	NO
Cardiovascular disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medicines.....	<input type="checkbox"/>	<input type="checkbox"/>
Muscular disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Communicable disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or frequent headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Seizures, convulsions or fainting.....	<input type="checkbox"/>	<input type="checkbox"/>	Other conditions being treated (<i>explain below</i>).....	<input type="checkbox"/>	<input type="checkbox"/>

EXPLANATIONS:
Attach additional sheet if needed

HEIGHT: _____ **WEIGHT:** _____ **BLOOD PRESSURE:** _____ **PULSE:** _____

	YES	NO		YES	NO
Immunizations are current.....	<input type="checkbox"/>	<input type="checkbox"/>	Currently taking medications.....	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATIONS:
Include dosage, frequency and time of day

Often transportation to camp is arranged via small, private aircraft. YES NO
In your opinion, this child is medically stable and able to fly in a small, non-pressurized aircraft?

SIGNATURE OF AUTHORIZED MEDICAL EXAMINER DATE OF EXAM

▪ **ATTACH A COPY OF CURRENT IMMUNIZATION RECORDS**