Camp Daniel 2022 Physician Form

Mail completed to: Camp Daniel, W10541 Army Ln, Athelstane, WI 54104
OR email to forms@campdaniel.org

1. THIS FORM MAY NOT BE SUBSTITUTED WITH PRIOR YEAR FORM OR ANY OTHER FORM.
2. EVERY SECTION MUST BE FILLED OUT, OR IT WILL BE RETURNED.
3. Upon receipt of completed form, an email will be sent to the email address you logged in with.

This medical information form must be completed & signed each year by a Doctor.
All applicants must have a medical exam within 12 months of program start date.

1. Applicant's **Last** Name: ____________________________ **First** Name: ____________________________

2. Height: _____ ft _____ in Weight: _________ lbs. DOB: _____ / _____ / _________

Blood Pressure: _______________ Pulse: _______________

3. Medical **Diagnosis**: ____

____

4. ALLERGY to Medication(s) & Reaction: ____

5. Other ALLERGY(s) & Reaction: ____

____

6. Enter **Date** of last **Tetanus** shot _____ / _____ / _________ (Must be within the last 10 years)

7. Hospitalizations and/or surgeries within the last 12 months:

Date: _____ / _____ / _________ Reason: ____

Date: _____ / _____ / _________ Reason: ____

8. If camper has had any of the following conditions, please give **age at onset:**

Anemia _____ Diabetes _____ Seasonal allergies _____ High blood pressure _____ Tuberculosis _____

Seizures _____ Headaches _____ Chicken pox _____ Asthma _____ Other ________________________

9. If ANY history of seizers: Date of last seizure: _____ / _____ / _________ Kind of seizure: ________________________

List all medications/treatment applicant is CURRENTLY taking for seizures: ____________________________

____

10. Are there any blood/body fluid precautions we should know about? **Yes** or **No** (circle one)

If yes, describe: ____

11. Check any medications the medical staff may **NOT GIVE** applicant as needed:

( ) Ibuprofen ( ) Tylenol ( ) Maalox ( ) Decongestant ( ) Anti-diarrheal ( ) Antihistamine

( ) Pepto Bismol ( ) Cough syrup ( ) Milk of Magnesia ( ) Other ____________________________

Signature of examining physician	Printed name of physician	Phone #	Date