Camp Daniel 2025 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.

Date of Physical:
_____ / _____ / _____

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

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

2. Sex: Male or Female (circle one) DOB: _____ / _____ / _____

Height: _____ ft _____ in Weight: _____ lbs. Blood Pressure: _____ / _____ Pulse: _____ bpm

3. Medical **Diagnosis**: _____

_____

4. ALLERGY to Medication(s) & Reaction: [ ] N/A _____

5. Other ALLERGY(s) & Reaction: [ ] N/A _____

_____

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

7. Hospitalizations and/or surgeries within the last 12 months: [ ] N/A

Date: _____ / _____ / _____ Reason: _____

Date: _____ / _____ / _____ Reason: _____

8. If camper has had any of the following conditions, please give **age at onset:** [ ] N/A

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 Health Center staff may **NOT GIVE** applicant as needed:

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

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

Office Use Only: Rec'd on:

□ Man Camp □ Girls WKND □ Spring WG □ Summer Camp □ Holiday WG

Note to Physician: Please do not include a copy of patient's chart.

Signature of examining physician	Printed name of physician	Phone #	Date