

CAMPER NAME: _____ Session: _____
 Last First Middle

Hindu Heritage Summer Camp Physician Examination

(To be filled out by the camper's physician/pediatrician)

Mail to: Dr. Piush Sharma
 2 Da Vinci Drive,
 Rochester, NY 14624

Medical Examination

Code: N= Normal A= Abnormal (Please explain)
 O= Not evaluated

Height _____	Weight _____
BP _____	Lungs _____
Skin _____	Heart _____
Eyes _____	Abdomen _____
Ears _____	GU _____
Nose _____	Extremities _____
Throat _____	Spine _____
Teeth (Braces) _____	
General Appraisal _____	

Immunization History:

Test	Most Recent Dates
DPT	_____
Booster	_____
MMR	_____
Polio	_____
HIB	_____
Varicella Vaccine	_____
Hepatitis B	_____
Menomune/Menactra	_____

(For Girls) Has this person menstruated? _____ If not, has she been told about it? _____ If so, is her menstrual history normal? _____ Special Considerations _____

Recommendations and Restrictions While at Camp:

Special Diet / Eating Disorder: _____

Swimming, Diving _____

Limitations to Activity _____

Allergies:

Medication _____	Food _____
Bee stings/Insect Bites _____	Poison Ivy _____
Other _____	

Health History: Y= Yes N= No (please explain)

Seizure Disorder _____	Diabetes _____	Musculoskeletal _____
Bed Wetting _____	Athletic Injuries _____	Bleeding/Clotting _____
Heart Abnormality _____	Mononucleosis _____	Asthma _____
Communicable Disease (specify) _____	Chronic/Recurring Illness _____	

Has camper been diagnosed with ADD or ADHD? _____ If yes, is the camper currently on medications? _____

List All Medications: (Prescribed & over-the-counter) and list conditions for which they are prescribed.

NAME	DOSAGE AMOUNT	FREQUENCY	DURATION	ROUTE	MD SIGNATURE
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

I have examined the person described above and have reviewed his/her health history. This person is physically able to engage in camp activities except as noted above. The date of last exam was _____

Physician name: _____ Phone: _____

Address: _____

Signature of examining Physician: _____ M.D. Date: _____