

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  
 3 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: \_\_\_\_\_