History and Physical Examination

Name: _____ **Date of Birth:** _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

Social Security No: _____ **Sex: Male Female** **I D Verified: ( ) TDL ( ) TID ( ) Other:** _____

Section I: Check all items that apply, **past** or **present** to your health history.

- Under current Medical, Dental, Mental Care, Treatment or Therapy
- Asthma / Respiratory Difficulty
- Lung Disease
- Tuberculosis
- Heart/Cardiovascular disease
- Anemia / Blood disorders
- Hemophilia / Bleeding disorders
- High Blood Pressure
- Kidney Problems / Dialysis
- Diabetes
- Thyroid Disease
- Gastrointestinal Problems
- Bowel Problems
- Nervous Stomach, Vomiting, Nausea
- Hernia
- Menstrual problems
- Hepatitis
- Cancer / Leukemia / Tumors
- Muscular Problems
- Head or Spine Injury
- Body Deformities
- Problems with Movement
- Strain(s) / Sprain(s)
- Infectious/Contagious disease
- Disability from Illness, Disease or Injury
- Extensive Confinement by Illness Disease or Injury
- Have you been refused to participate at camp or athletics for health reasons?
- Nervous Disorders
- Nervous Breakdown
- Psychiatric Disorder
- Suicide Attempts/Thoughts
- Mental Health Problems
- Sweating / Tremors
- Convulsion, Seizures, Fits
- Mental Retardation
- ADD / ADHD / Autism
- Allergies (Medication)
- Allergies (Food)
- Allergies (Plants)
- Allergies (Sting insects)
- Allergies (Animals)
- Sensitivity to Sunlight
- Sleeping walking /nightmares
- Bed-wetting
- Constipation / Diarrhea
- Frequent nosebleeds
- Frequent headaches
- Motion sickness
- Dizzy Spells / Fainting
- Hospitalization(s) Surgery(s)

Assistive /Corrective Devices

- Glasses • Contacts
- Hearing aids
- Dentures • Retainer
- Pacemaker
- Special Diet
- Back / neck braces
- Special pillow or support
- Joint replacements
- Artificial limbs/prosthesis
- Cane/Crutches/Walker
- Wheelchair
- Wheelchair van
- Other special needs
- Medications/Prescriptions
- Inhaler

REMARKS: _____

Section II MEDICAL PROFESSIONAL USE ONLY (Check if normal; Circled if abnormal) N/A = Deferred

General Appearance: Neat Poor Hygiene Behavior: Alert Orientated Non-aggressive Aggressive Confused Dis-orientated

Height	Weight	Blood pressure /
Heart Rate	Temperature N/A	Respirations
Vision Rt.20/ Lt.20/	Pupils Equal Unequal	Hearing Rt. Lt.
Eyes	Ears	Nose
Mouth/Throat	Heart	Pulses
Lungs	Abdomen	Hernia umbilical, inguinal, femoral
Upper Extremity ROM	Lower Extremity ROM	Skin
Neck ROM	Back ROM	DTR's Biceps, Triceps, Brach, Patellar, Achilles, Babinski

- No medical restrictions are indicated:
- Accommodations recommended:
- Recommended medical restrictions / limitations:
- Unable to perform essential functions or *"significant risk"* possible:
- Recommend further evaluation / treatment:

Remarks/Comments: _____

_____

_____

_____.
Physician Signature

Joseph H. Lones III, DC
10102 North Lamar Blvd
Austin, TX 78753
(512) 835-1955

_____
Date

Section III: Health Care & Camp Permission *Camper/Parent /Guardian(s) must initial & sign statements below:*

_____ I give my permission for first aid techniques & simple health care to be administered as the need arises. I understand in the event of any serious injury or illness on the part of myself or my child, the camp officials reserve the right to seek professional medical attention including but not limited to consultation with medical director, EMS transportation, and hospitalization.

____ I give permission for myself or my child, in consultation with the Camp Health Supervisor and/or the medical director's standing orders to be given the following medications as indicated below:

___ Acetaminophen (i.e. Tylenol) ___ Ibuprofen (i.e Advil) ___ Decongestant (i.e Sudafed) ___ Antihistamine (i.e Benadryl)

___ Antihistamine Cream ___ Antibacterial Ointment ___ Antacid Tablet (i.e Tums) ___ Additional Medications as indicated/Rx by Medical Director

____ All campers may be screened for signs & symptoms of illness (i.e. elevated oral temp.) and contagious disease / infestation (i.e lice), and may be denied participation based on such findings until resolved.

I hereby attest that all information listed on this form is complete and accurate to the best of my knowledge, and that the camper is in acceptable health, physical ability, and emotionally ready to fully participate in camp. I grant my permission as the camp mentioned on this form to participate in all activities associated with the enrolled event(s) with the exceptions that are noted by physician or myself.

Camp physicals are performed to determine if camper is suitable, physically, mentally and emotionally to participate with camping related activities. Camp physicals are not intended to substitute regular health maintenance examinations. The purpose of the examination is to screen for life-threatening or disabling conditions, and screen for conditions that may predispose to injury or illness. In all cases the physical examination may not identify all potential problems that may be present.

_____ _____

Signature *Date*

Section IV: Camper Restriction(s) ***(as defined by camper, parent/guardian or physician)***

- Camper requires a special dietary regimen / modification. _____
- Camper is under care of a medical professional. _____
- Activity camper should not participate. _____
- Does camper require specialized care outside the scope of standard childcare?_____

Section V: Medication Record ***All prescription and non-prescription medication must be labeled with camper's name and current dosage. Dosage of non-prescription(s) may not exceed product recommendation without physician's written orders.***

Medication	Dosage	Frequency	Purpose
1.			
2.			
3.			