History and Physical Examination

Nombre (y apeido): _____ **Fecha de nacimiento:** _____ **Edad:**_____

Dirección: _____ **Ciudad:** _____ **Estado:** _____ **Zip:** _____

Teléfono Casero: _____ **Teléfono Del Trabajo:** _____ **Celular:** _____

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

Section I: Compruebe todos los artículos que se apliquen, Más Allá de o Presente Historia De la Salud

- Estas agarando Meidicamiento, Dental, Mental, Ayuda , tratamiento o terapia

- Asma / Dificultad Respiratoria
- Enfermedad De la Pulmón
- Tuberculosis
- Enfermedad del corazón
- Anemia / desorden de sangre
- Hemophilia / Bleeding disorders
- Alta presion
- Enfermedad del Riñón / Diálisis
- Diabetes
- Enfermedad de Tiroides
- Enfermedad de gastrointestinales
- Problemas del Intestino
- Estómago nervioso
  El vomitar, náusea
- Hernia
- Meses faltados de arregla
- Hepatitis
- Cáncer / Leukemia / Tumores
- Enfermedad Muscular

- Cabeza o lesión de la espina dorsal
- Cuerpo derformado
- Deformidades Del Cuerpo
- alguna falsiada de coyunturas
- Enfermedad Infecciosa
- Desabilidad de enfermedad
- Inhabilidad de la enfermedad
- Has sido rechasado por participar en campamiento o deportes por razones de enfermedad?
- Desorden de Nervios
- Nerviocidad
- Desorden Psiquiátrico
- Suicidio attempt/Thoughts
- Problemas de Salud Mentales
- El Sudar / Temblores
- Asimientos,Convulsiones,
- Retraso Mental

- ADD / ADHD / Autism / heperatino
- Medicación de la Alergias
- Alergias del Alimento
- Allergies (con plantas)
- Alergias (mordidas de insectos)
- Allergies (con aminales)
- Sensativo con el Sol
- Pesadia o camnina en su sueno
- Problema con orina en cama
- Constipacions / Diarrea
- Sale sangre de la nariz frequente
- Dolores de cabeza Frequente
- Mosion de enfermedad
- Mareos o demayos
- Hospitalización / Cirugías (s)

Assistive / Dispositivos Correctivos

- Lentes ópticas
- Lentes de contacto
- Prótesis de oído
- Dentaduras• Detenedor
- Marca de pasos
- Dieta Especial
- Apoyo de la espina dorsal / Apoyo del cuello
- Muada especial o soporte
- Reemplazos comunes
- Limbs/prostesis artificial
- Cane/Crutches/Walker
- Silla de ruedas
- Furgoneta Del Sillón de ruedas
- Otras especiales necesidades
- Medicación /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.			