Easterseals Wisconsin Camps Medical Examination Form

To be completed by Licensed Medical Personnel
(Physician, Physician Assistant or Nurse Practitioner)

Please list the applicant's primary physician if different from the licensed medical personnel filling out the form. The person named below has been accepted to camp and has permission to engage in all camp activities except as noted below. Easterseals Wisconsin Camps has been given permission to provide routine health care under the guidance of the camp's medical director, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests by the Camper/Guardian signing the releases section of the camp application. The person named below has also agreed to release any records necessary for treatment, referral, billing, or insurance purposes.

By the camper/guardian signing the releases section on the camp application, Easterseals Wisconsin Camps has been given permission to arrange necessary related transportation for the person named below. If the guardian/ parent cannot be reached in an emergency, they hereby gave permission to the physician selected by the camp to secure and administer treatment, including hospitalization, by signing the releases section of the camp application.

Camper Name:_____Date of Birth___/____/ Camper

Address: _____

Camper Home Phone #: (_____)_____Cell Phone #: (_____)_____

Primary Physician:_____Phone #: (_____)_____

Emergency Contact (name & relation):_____Phone #: (_____)_____

I examined this individual on___/____/_____. Easterseals Wisconsin requires **annual exams**. **A new exam is not necessary if you have a copy of a current and comparable physical form used for another camp/program.**

BP:_____Pulse:_____Weight:_____Height:_____

02 Saturation:_____Free of Communicable Disease as of____/____/_____

Allergies: _____

Record of immunizations and date received (*required): COVID(1st)___/___/___ (2nd)___/___/___ Booster __/__/__

Tetanus/TDAP ___/___/___ Influenza___/___/___ *MMR (1st) ___/___/___ *MMR (2nd)___/___/___

List any additional immunizations & dates (MMR titer date and result if unable to complete vaccinations): _____

_____

Description of any camp activity restrictions: _____

_____

_____

_____

Additional health information / seizure plan / allergy plan / behavior plan: _____

Any medically prescribed meal plans or dietary restrictions: _____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which camp staff should be made aware.

I have examined the herein named individual and have reviewed the health history and find this person to be free of any contagious disease. I find this individual able to participate in a camp experience with the previously listed limitations.

Signature of Licensed Medical Personnel Date

Printed Name Title

Address

Phone Fax