

Physical Exam

Health Care Provider: Please complete this page

Child's Name _____ Date of Birth _____

Date of Last Physical Exam _____ Recent Weight _____

Vision Exam _____ Hearing Exam _____

Physical Exam: Normal Abnormal

If abnormal, please explain _____

Significant Health Concerns: None Seizures Diabetes Developmental Delay Vision Hearing

Hospitalizations Operations Allergies

Other (please describe) _____

Explain above concerns (if necessary, include instructions for school staff) _____

Current Medications: _____

Do Medications Need to be Kept/Given at Camp? Yes No (If yes, a separate medication consent form must be completed)

Dietary Concerns _____

Immunizations up to Date? Yes No (Please attach immunization record)

Any additional information, recommendations, or restrictions? _____

Signature

I attest that this child is healthy to attend Broomfield UMC Summer Camps in routine activities. Any concerns or exceptions are identified on this form.

Name of Health Care Provider _____

Title _____ Date _____

Signature of Health Care Provider _____