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. Wisconsin Badger Camp 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, Wisconsin Badger Camp 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 _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____)_____

Parent/Guardian Name: _____ Relationship: _____Phone: (___)_____

Primary Physician: _____Phone #: (_____)_____

Medical Assistance/I.D. # _____ Insurance #: _____ Group #: _____

Insurance Company: _____ Insurer's Name: _____

I examined this individual on ___/____/_____. Wisconsin Badger Camp requires **annual exams**. ALL exams must be completed on this form and returned to camp *three weeks before camp attendance.* **Medical Exams completed on any other documentation will NOT be accepted.**

BP:_____ Pulse: _____Weight: _____Height:_____

Free of Communicable Disease as of _____

Description of any camp activity restrictions:

Strenuous Exercise/Physical Activity:

Hiking:

Swimming:

Other Restrictions:

Blood/Body Fluid Precaution: (circle one) Yes / No | If yes, Type: _____

Non-Drug Allergies (please explain reaction):_____

_____

Drug Allergies (please explain reaction):_____

_____

Does this person have a history or experienced seizures or convulsions? _____ Date of last seizure:_____

Type of seizures: _____ Frequency: _____

At what point do we call EMS? _____

Additional information regarding seizures: _____

_____

THIS FORM IS TO BE RETURNED NO LATER THAN THREE WEEKS PRIOR TO ATTENDANCE.

Has this person been immunized against the following? If so, the most recent date,
MMR #1_____ MMR #2_____ Tetanus_____ Pertussis_____ TB Skin Test_____

Hep B Vaccine #1: _____ Hep B Vaccine #2: _____ Hep B Vaccine #3: _____

If not immunized for tetanus in the past 10 years, please do so prior to attendance.

Is the following normal? If abnormal, please Explain.

	Normal	Abnormal	Explanation
Ears			
Nose			
Throat			
Skin			
Eyes			
Scalp			
Heart			
Lungs			
Extremities			
Abdomen			
Varicosities			
Genitalia			
Neurologic			

Is there a history of the following? If yes, explain.

	History	No History	Explanation
Asthma			
Hernia			
Kidney Disease			
Diabetes			
TB			
Hepatitis			
Heart Disease			
Freq. Colds			
Stomach Disorders			
Previous Surgery			
Recent Illness			
Other			

Further recommendations for camp medical staff (current health conditions requiring additional attention, treatment, or special considerations while at camp):_____

_____

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

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