Primary Care Provider Physical Exam Form

TO BE COMPLETED BY PROVIDER'S OFFICE

Patient's Name: _____
First MI Last

D/O/B: ____/___/____ Date of Physical: ____/___/____ (Must be within 1 year from date of camp)

Weight at last exam: _____ Medical Problem List: _____

_____

Immunizations up to date: Yes _____ No_____ Date of last Tetanus: _____/_____/_____

Allergies: _____

Medications:

Medication	Dosage	Frequency

Do you have any concerns/abnormalities from the patient's last physical?

Please explain: _____

_____

Are there any behavioral or emotional issues, or any issues that may cause the camper to be a risk to him/herself or others? Please explain: _____

_____

Is there any other info that would help ensure a fun, successful camp experience? _____

_____

PLEASE RETURN THE COMPLETED FORM TO THE APPLICANT
OR FAX TO Louise D'Amato @ 401-444-7619. THANK YOU!

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

_____ _____
Examining Pediatrician Signature Examining Pediatrician (Print Name)

_____ _____
Date Phone

Hasbro Children's Hospital
The Pediatric Division of Rhode Island Hospital
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