Camp Sun 'N Fun
2023 Physical Examination Form

Camper's Name:____

Male   Female   Non-Binary   Date of Birth:__________Age:________________

Address:____

City:________________________State:__________________Zip:________________

Examining Physician:_______________________________________

Address:____

City:________________________State:_______Zip:________Phone:_____________

HEALTH HISTORY

Date of Last Tetanus/Booster:__________(Month/Year)

Dates of Covid-19 Vaccine Series': ___________ ______________ ____________

***You must attach a copy of your Covid vaccination record or NJ docket.**

DISEASES

	Y	N	Date		Y	N	Date
CoVid-19				Heart Defect/ Disease			
Chicken Pox				Diabetes			
Measles				Bleeding/Clotting Disord.			
Mumps				Hepatitis			
Asthma				Other			

ALLERGIES

	Y	N		Y	N
Hay Fever			Penicillin		
Poison Ivy, etc.			Foods		
Insect Bites			Other		

Food Allergies:____

Operations or serious injuries (please include dates): _________________________

____

Seizure Disorder: Yes or No   Type:________________Normal Duration: _______

MEDICAL EXAMINATION

Height:______Weight:_________T:________P:_______R:________BP:__________

Eyes/Nose/Throat: ________________

Musculoskeletal:_________________

Cardio & Vascular:________________

Abdomen: _____________________

Skin: ____________________

Mental/Neuro: ________________

MEDICATIONS

Rx and Regular OTC, use separate sheet if needed

Medication	Dose	Route	Frequency	Reason	Date Started

ACTIVITY RESTRICTIONS

	Yes	No
Outdoor Sports		
Sun/Heat Tolerance		
Swimming		
Performing Arts/Dancing		
Nature/Outdoor Activities		
Extensive Walking		

Recommendations or restrictions for any of the above activities while at camp:

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To the best of my knowledge, I verify that the above-named camper is physically able to engage in program activities, except as noted above and is free of any contagious or communicable diseases.

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Signature of Examining Physician Date