

HEALTH PROVIDER'S REPORT

NAME _____ Date of Birth _____ Age _____

DATE of most recent health check/Physical Exam _____ By: _____

Height _____ Weight _____ BP _____ P _____ R _____

Significant Health History:

Allergies? -No -Yes - Specify: _____

Asthma? -No -Yes - Triggers? _____

Sports injuries? -No -Yes- Specify _____

Hospitalizations? -No -Yes - Year/Reason? _____

Surgeries?: -No -Yes - specify _____

Other-specify: _____

Physical Exam:

NI	Abn	Comments
___	___	Head _____
___	___	Hair/scalp _____
___	___	Eyes _____
___	___	ENT _____
___	___	Teeth _____
___	___	Neck/Nodes _____
___	___	Chest _____
___	___	Heart/pulse _____
___	___	Abdomen _____
___	___	GU/Gyn _____
___	___	Neuro _____
___	___	Spine _____
___	___	Extremities _____
___	___	Skin _____

Diagnosis: - Healthy; no activity/other restrictions for camp.

- Diagnosis/problem _____

- CAMP RESTRICTIONS: _____

Camper's MEDICATIONS (daily, regular, as needed) to be continued at camp. Cite fully. _____

TREATMENTS to be continued at camp? -No -Yes. What? _____

BEHAVIORAL, emotional, educational difficulties? -No -Yes - Note _____

IMMUNIZATIONS (Please attach record). TETANUS (most recent): Type _____ Date _____

Signature of person completing form _____ Date _____

Print Name _____ Title _____

PROVIDER _____ **Address** _____

Title _____ **Fax #:** _____

Practice _____ **Phone #:** _____

<p>RETURN FORM TO CAMPER, or MAIL to: BETHEL HORIZONS OR FAX to BETHEL HORIZONS @ 312 WISCONSIN AVE. Madison office: 608-257-4044 MADISON, WI 53703 Dodgeville/camp: 608-935-0216</p>
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