LABCC CAMPER PHYSICAL FORM

To be completed by Physician/Healthcare Provider and signed by Parent **FORM DUE: JUNE 1st**

Camper Name:_____ Birth date:_____/_____/_____

Last First Month Day Year

PHYSICAL EXAMINATION: (to be performed by licensed physician/MD/DO, physician assistant or nurse practitioner within 12 months of camp end date)

Camp Morning Star is located in the San Bernardino Mountains approximately 85 miles from Los Angeles, CA. Site elevation ranges from 5,000 to 7,000 feet in typical forested and chaparral mountain terrain. The LABCC Summer Camp involves children in a variety of religious learning, social, and recreational activities in all weather conditions. Examples of some activities include: hiking, swimming, camping in hot and cold weather conditions as well as environmental exposure to dust/pollen and bees. Standardized, well-balanced meals are provided. Children sleep in bunk beds in cabins shared with other children, as well as outdoor overnight campouts. Bathroom facilities are located either in or outside of cabins. The children stay at Camp Morning Star for eight days.

Date of Exam	Height	Weight	Blood pressure	Pulse

	Normal	Abnormal	Explain Any Abnormalities
Eyes			
Ears/Nose/Throat			
Lungs			
Heart			
Abdomen			
Genitalia			
Musculoskeletal			
Neurological			
Other			

Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
Knees (both)			
Ankles (both)			
Spine			

Other	No	Yes	
Contacts			
Braces			
Dentures			**Explain**
Medical equipment (ie, CPAP, oxygen)			

ALLERGIES:
(specify agent, type of reaction, treatment)

MEDICATIONS: List all medications, including any over-the-counter medications. If additional space is needed, please attach separate sheet.
NOTE: medications need to be have original containers and labels. Do NOT send expired mediations or pill boxes.
Rescue inhalers (please send 2 if possible) and EpiPen information **must** be included, even if they are for occasional or emergency use only.

Medication		Medication		Medication	
Dose		Dose		Dose	
Frequency		Frequency		Frequency	
Reason for use		Reason for use		Reason for use	
❒ Routine use	❒ As needed use	❒ Routine use	❒ As needed use	❒ Routine use	❒ As needed use
Medication		Medication		Medication	
Dose		Dose		Dose	
Frequency		Frequency		Frequency	
Reason for use		Reason for use		Reason for use	
❒ Routine use	❒ As needed use	❒ Routine use	❒ As needed use	❒ Routine use	❒ As needed use

I approve administration of medications listed above. A member of the LABCC Summer Camp may administer medication(s).
I certify that I have reviewed the health history, immunization history and examined the individual listed above and find no contraindications for participation in LABCC Summer Camp and believe he/she is able to attend camp and participate as below. I will notify the LABCC Summer Camp immediately of changes in my patient's condition or medication(s) and/or the patient is no longer under my care.

❒ **All camp activities with the following restrictions:** _____

(Restrictions subject to review and approval by LABCC board to ensure camp activities/environment can provide a safe and constructive experience for campers)

Physician Name:	**Physician Signature:**	**Date:**
Physician Address:		**Physician Phone:**

Parent / Legal Guardian Signature:	**Date:**

Signatures of both HEALTHCARE PROVIDER and PARENT/LEGAL GUARDIAN required for administration of medications