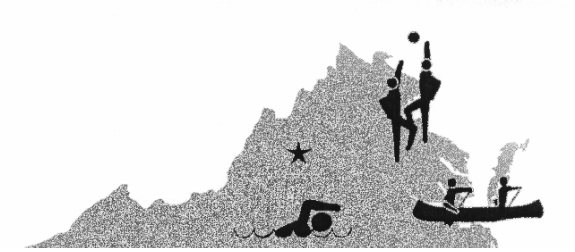
Central Virginia Burn Camp
1960 Candlewyck Drive
Charlottesville, VA 22901
(434) 263-6566
fax (434) 975-0080
cvbc1999@yahoo.com
www.vaburncamp.org



Camp Directors

Leslie Baruch ***Tim Wright***

PHYSICIAN'S REPORT

Page 1 **TO BE FILLED OUT BY PHYSICIAN**

To be completed by a licensed M.D. prior to arrival at camp. The purpose of this report is to ascertain whether the camper a) can engage in strenuous activity; b) has a communicable disease that could be conveyed to others; c) has a medical, physical, or emotional condition needing the special attention of the camp staff.

CAMPER'S NAME _____

1. Does the camper have any significant:
   a) Medical condition _____no _____yes
   b) Physical condition _____ no _____yes
   c) Emotional condition _____no _____yes
   d) Psychological condition _____no _____ yes
   e) Communicable disease _____no _____yes
   f) Allergic condition _____no _____yes

If yes on any of the above, please explain:

Condition or Disease Treatment

_____

_____

_____

2. Does the camper need medications while at camp? _____no _____yes

Medicines Routes, Dosages, and Frequency

_____

_____

3. Immunizations MUST BE current to participate in camp.
   Camper's immunizations are current: _____yes _____no

4. If this patient is over 12 years old, has he/she had his/her 2nd MMR

vaccination? _____no _____yes

PHYSICIAN'S REPORT
Page 2

5. Does patient have epilepsy? _____no _____yes
6. Does patient have diabetes? _____no _____yes
7. Does patient have any allergies? (food, drug, plants, insects, etc…)
   _____ no _____yes If yes, please explain: _____
   _____

8. Name of family physician: _____

   Phone number: _____

9. Is there any condition that you feel would prevent this camper from participating in strenuous activity or are there limitations you would like built into his/her activity program? _____no _____yes If yes, please comment: _____
_____
_____

10. **Physical Exam** (/ normal, x abnormal)
    Date _____/_____/_____ Height _____ft. _____in. Weight _____lb.

    Blood Pressure _____/_____ Pulse _____/ minute

    Vision OD _____ OS _____ Throat _____ Chest _____
    Genitalia _____ Neck _____Heart _____ Hernia _____
    Eyes _____ Lungs _____ Abdomen _____ Lymph nodes _____
    Ears _____ Nose _____ Thyroid _____

GENERAL COMMENTS : _____
_____
_____

DOCTOR'S SIGNATURE: _____

DOCTOR'S NAME: _____
(please print)
DATE _____**/**_____**/**_____ **PHONE** _____**-**_____**-**_____

ADDRESS: _____
(street)
_____
(city) **(state)** **(zip code)**