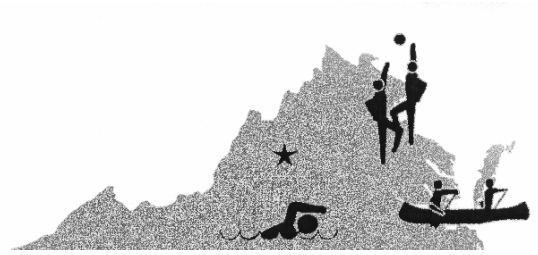


**Central Virginia Burn Camp**

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*Camp Directors*

*Leslie Baruch*

*Tim Wright*

*Julie Bonham*

**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:
- 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

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2. Does the camper need medications while at camp? \_\_\_\_\_no \_\_\_\_\_yes

Medicines

Routes, Dosages, and Frequency

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3. Immunizations **MUST BE** current to participate in camp.

Camper's immunizations are current: \_\_\_\_\_yes \_\_\_\_\_no

**PHYSICIAN'S REPORT**

**Page 2**

- 4. If this patient is over 12 years old, has he/she had his/her 2<sup>nd</sup> MMR vaccination? \_\_\_\_\_no \_\_\_\_\_yes
- 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:** \_\_\_\_\_

**DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_ **PHONE** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(please print)

**ADDRESS:** \_\_\_\_\_  
(street)  
\_\_\_\_\_  
(city) (state) (zip code)