



## MELODY PINES DAY CAMP PHYSICAL EXAM FORM

If your medical provider **does not** provide his/her own form, please have him/her complete and sign this form.

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Ref: Yes / No \_\_\_\_\_

Scoliosis: Screen: \_\_\_\_\_ Ref: Yes / No \_\_\_\_\_ B/P: \_\_\_\_\_ Ref: Yes / No \_\_\_\_\_

**Health Assessment:**

	Normal	Abnormal	Needs Follow-up	Not Examined
Lead Level				
Vision / Right				
Vision / Left				
Hearing / Right				
Hearing / Left				
Skin/Scalp				
Nutrition				
Neurological & Muscular				
Spine & Extremities				
Eyes				
Ears				
Nose, Throat, Mouth				
Glands (including Thyroid)				
Chest, Breasts				
Heart, Lungs				
Abdomen				
Genitalia				

A. Any chronic illness that may require medication or special accommodations (e.g. seizure disorder, food allergies, asthma)?

B. Pertinent past family/medical history:

C. Developmental/Psychosocial /Emotional Assessment:

D. Updates in Immunizations Boosters given:

***Attach updated Immunization Record***

The above named patient has been determined to be in good health and may participate in day care, school, sports, camp with:

Restrictions: \_\_\_\_\_ No restrictions \_\_\_\_\_ **Date of Exam:** \_\_\_\_\_

Licensed Provider's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Licensed Provider's Name: (Please print): \_\_\_\_\_