Camp Oak Hill Physical and Immunization Form

THIS FORM TO BE COMPLETED BY A LICENSED PHYSICIAN

Last Name **First Name** **Date of Birth**

PHYSICAL

Weight:_____ Height:_____ B.P. _____/_____

CODE (check if normal, comment if abnormal)

☐ Skin	_____	☐ Nose	_____
☐ Chest	_____	☐ Extremities	_____
☐ Eyes	_____	☐ Throat	_____
☐ Heart	_____	☐ Spine	_____
☐ Ears	_____	☐ Teeth	_____
☐ Abdomen	_____	☐ Neurologic	_____

Menstrual Cycle (if applicable):_____

Restrictions (diet, activity, etc.): _____

Known Allergies: _____

Does this individual have chronic medical problems, emotional difficulties, eating disorders or behavioral issues of which you are aware? If yes, please attach a description of the condition.

Does this individual take routine medications or **nutritional supplements**? **If yes, please attach a list of medications**.

To coincide with N.C. law for school enrollment, Camp Oak Hill strongly recommends the following immunizations. A copy of the immunization record must be attached.

Required by State Law: DTP/DTaP/DT; Polio (IPV/OPV); MMR (combined doses)
Required by State law if child is 12 years or older: dT; TdaP
Required by State law for children born on or after 10/01/88: Hib
Required by State law for children born on or after 07/01/94: Hepatitis B
Required by State law for children born on or after 04/01/01: Chicken Pox

If camper lacks any recommended immunizations, parent/guardian must fill out the attached Immunization Exemption Form.

MY SIGNATURE INDICATES *that I have reviewed this patient physical form (above) as well as examined this patient on _____ Date of Exam (within 12 mos of arrival to Camp).*

PHYSICIAN'S SIGNATURE: _____ Date:_____

Print or Stamp
Physician's Name
Mailing Address
Phone Number

Please return this form along with immunization records or waiver to:
medical@campoakhill.org