

Primary Care Provider Physical Exam Form

TO BE COMPLETED BY PROVIDER'S OFFICE



Patient's Name: _____
First MI Last

D/O/B: ____/____/____ Date of Physical: ____/____/____ (Must be within 1 year from date of camp)

Weight at last exam: _____ Medical Problem List: _____

Immunizations up to date: ____ Yes ____ No Date of last Tetanus: ____/____/____

Allergies: _____

Medications:

Medication	Dosage	Frequency

Do you have any concerns/abnormalities from last physical?

Please explain: _____

Any behavioral or emotional issues, or any issues that may cause the camper to be a risk to him/herself or others?

Please explain: _____

Any other info that would help ensure a fun, successful camp experience?

**PLEASE RETURN THE COMPLETED FORM TO THE APPLICANT
OR FAX TO Louise D'Amato @ 401-444-7619. THANK YOU!**

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

Examining Pediatrician Signature

Examining Pediatrician (Print Name)

Date

Phone Number



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