



CAMPER PHYSICAL RECORD

To be filled out by child's Physician.
Please mail this form back to:

Camp Grace Bentley

8250 Lakeshore Rd

Burtchville, MI 48059

Patient's Name _____

TO BE ANSWERED BY PHYSICIAN

HEIGHT _____

WEIGHT _____

BLOOD PRESSURE _____

S=Satisfactory X=Not Satisfactory O=Not Examined

EYES _____

EARS _____

NOSE _____

THROAT _____

TEETH _____

HEART _____

LUNGS _____

ALLERGY _____

PLEASE SPECIFY _____

ABDOMEN _____

EXTREMITIES _____

POSTURE _____

SKIN _____

ASTHMA _____

PARASITES _____

HERNIA _____

All shots are up-to-date Yes _____ No _____

MEDICATIONS:

All medications must be in the original container with the child's name and dosage amount. We can not deviate from these directions.

Please send the exact amount of medication needed for the entire session.

MEDICATION NAME _____

DOSAGE _____

TIME TAKEN _____

MEDICATION NAME _____

DOSAGE _____

TIME TAKEN _____

MEDICATION NAME _____

DOSAGE _____

TIME TAKEN _____

SEIZURES Yes No

EMOTIONAL/ BEHAVIORAL PROBLEMS Yes No

BOWEL/BLADDER Yes No

CATHETER ___ Self ___ Yes ___ No ___

Assistance Yes ___ No ___

RESTRICTIONS:

TO SWIM Yes No

STRENUOUS ACTIVITY Yes No

DIAGNOSIS _____

SPECIAL EQUIPMENT _____

PRECAUTIONS (Explain in detail) _____

RECOMMENDATIONS AND OTHER RESTRICTIONS WHILE AT CAMP _____

GENERAL CONDITION OR APPRAISAL _____

I have examined the individual 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, and is free from contagious diseases as specified above.

Name of Examining Physician _____ Date _____

Signature _____

Address _____

City _____ State _____ Zip _____

Telephone _____

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