

**Sarah Behn Basketball Camp
Physical/Immunization Form**

PHYSICAL EXAM

Camper's Name: _____ Date of Birth _____

The above patient was examined on _____.
The patient's health history and immunization records were reviewed.

Weight: _____ Height: _____ BP: _____

Vision: Left _____ Right _____ Color _____ Postural Screen _____

Allergies: _____

Chronic Medical Problems: _____

Medications/Treatments: _____

Dietary Restrictions: _____

I SEE NO REASON(S) TO RESTRICT FULL PARTICIPATION IN CAMP ACTIVITIES.

Physician's Name (Printed): _____ Phone #: _____

Physician's Signature: _____ Date: _____

**PARENTS: I CERTIFY THAT MY CHILD HAS NOT INCURRED ANY SIGNIFICANT HEALTH
 PROBLEM(S) SINCE THE DATE OF THE ABOVE PHYSICAL EXAM.**

Parent's Signature: _____ Date: _____

IMMUNIZATION RECORD WITH MONTH/YEAR OF ADMINISTRATION

DPT/DTaP/DT	OPV/IPV	HIB	Hept B	LEAD Date/Result
	MMR	Varivax	Influenza Vacc	TB Risk Screen
Td				
Other Immunizations		Chicken Pox		