SUMMER 2024

STAFF PHYSICAL EXAM FORM

NOTE: WE PREFER THAT THIS FORM IS USED EXCLUSIVELY (INTERNATIONAL STAFF MAY UPLOAD THEIR VISA SPONSOR AGENCY'S MEDICAL FORM IN LIEU OF THIS FORM). THIS EXAM MUST BE COMPLETED AFTER AUGUST 1ST OF LAST YEAR, AND BEFORE THE START OF CAMP. ONCE COMPLETE, PLEASE UPLOAD A COPY TO YOUR WORKBRIGHT ACCOUNT.

STAFF'S LAST NAME: _____ STAFF'S FIRST NAME: _____

DATE OF BIRTH: _____ AGE AT CAMP: _____ GENDER: _____

EXAM DATE: _____ BP: _____ Weight: _____ Height: _____

CONDITION OF
Throat: _____ Eyes: _____ Ears: _____ Sinuses: _____ Teeth: _____ Abdomen: _____ Lungs: _____

Any heart disorder?: _____ Skin (athlete's foot, impetigo, ringworm, etc.): _____

Orthopedic: _____ Vision (Left): _____ Vision (Right): _____

Any known exposure to (indication of) communicable disease currently?: _____

RECOMMENDATIONS & RESTRICTIONS AT CAMP

In my opinion, the above applicant ☐ **IS** ☐ **IS NOT** able to participate in an active camp program.

Description of any limitation or restriction on camp activities: _____

The applicant is under the care of a physician for the following conditions: _____

Treatment to be continued at camp: _____

PRESCRIBED & REGULAR MEDICATIONS

PLEASE NOTE: For the safety of every person in camp, all medications must be kept under lock and key, whether in Camp Medical Staff's possession or staff member's personal locker in the staff lounge. Whether such medication is self-administered by the staff member themself, or by the medical staff, will be at the discretion of the Camp Medical Staff. It is the staff member's responsibility to take medication in compliance with instructions indicated by their doctor. Please list any medication being brought to camp, showing name of medicine, what it is for, and Doctor's recommended dosage. This information is necessary for the Camp Medical Staff's records and staff member's permanent file.

May Tylenol be given if needed? ☐ **YES** ☐ **NO** State preferred alternate: _____

THIS STAFF MEMBER TAKES MEDICATION AS FOLLOWS: *PLEASE ATTACH ADDITIONAL PAGE(S) FOR MORE MEDICATIONS.*

MED #1: _____ Dosage: _____ Specific times taken each day: _____

Reason for taking: _____

MED #2: _____ Dosage: _____ Specific times taken each day: _____

Reason for taking: _____

MED #3: _____ Dosage: _____ Specific times taken each day: _____

Reason for taking: _____

KNOWN ALLERGIES: _____

Any medically-prescribed meal plan or dietary restrictions?: _____

IMPORTANT!: *If needed, please attach additional pages to provide more information for camp medical staff.*

Signature of Licensed Medical Personnel: x _____

Print or Typed Name: _____ Title/License Type: _____

Phone: _____ Date: _____

Address: _____

SCREENING RECORD (THIS BOX FOR CAMP USE ONLY!)

Date screened: _____ *Time:* _____ *Meds given to FPC Med Staff?* _____ ***Initials:*** _____ *Updates/additions?:* YES NO

Observational Notes: _____