

Hoop Mountain Medical Form
Physician Report
(This is to be completed by a physician)

THE INFORMATION ON THIS FORM MUST BE CURRENT WITHIN TWO YEARS OF CAMP ATTENDANCE.

Camper's Name: _____ D.O.B _____

Height: _____ Weight: _____ Age: _____ Blood Pressure: _____ Sex: _____

SIGNIFICANT ILLNESS AND OPERATIONS: (Check only if satisfactory, give details if not.)

Measles _____ German Measles _____ Scarlet Fever _____ Mumps _____

Chicken Pox _____ Diabetes _____ Hypertension _____ Mononucleosis _____

Convulsions _____ Asthma _____ Heart Defects/Disease _____

Bleeding/Clotting Disorders _____ Allergies _____

Other _____

Details _____

IMMUNIZATION SUMMARY: HISTORY OF ALL SHOTS TAKEN

Date & Year IMMUNIZATION BOOSTER

DPT _____ DT _____

TETANUS _____

POLIO OPV _____

MEASLES _____

GERMAN MEASLES _____

MUMPS _____

MANTOUX TUBERCULIN _____

HAEMOPHILUS INFLUENZA _____

HEPATITUS B _____

CURRENT EXAMINATION: (Check if satisfactory; circle if unsatisfactory and give details)

Eyes _____ Hearing _____ Heart _____ Hernia _____ Posture _____ Vision _____

Throat _____ Lungs _____ Musc/Skel _____ Genitalia _____ Ears _____ Teeth _____

Abdomen _____ CNS _____ Skin _____

Any notable conditions: Glasses, etc.) _____

Medicine to be administered, specific dosages, and frequency _____

Physician's Summary Statement: This is to certify that I have examined this person, on this date, and found him/her to be in good physical condition. There is no evidence that he/she should not participate in all camp activities, except as stated. I have noted any restrictions, conditions, and required medications.

Signed _____ M.D. Date _____

Print Name _____

Address _____ Telephone _____

Mail to: Hoop Mountain, PO Box 7068, Beverly, MA 01915 OR

Fax to: 978-922-3348