



# Medical Examination Form

To be completed by Licensed Medical Personnel  
(Physician, Physician Assistant or Nurse Practitioner)

Please list the applicant's primary physician if different from the licensed medical personnel filling out the form. The person named below has been accepted to camp and has permission to engage in all camp activities except as noted below. Wisconsin Badger Camp has been given permission to provide routine health care under the guidance of the camp's medical director, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests by the Camper/Guardian signing the releases section of the camp application. The person named below has also agreed to release any records necessary for treatment, referral, billing, or insurance purposes.

By the camper/guardian signing the releases section on the camp application, Wisconsin Badger Camp has been given permission to arrange necessary related transportation for the person named below. If the guardian/parent cannot be reached in an emergency, they hereby gave permission to the physician selected by the camp to secure and administer treatment, including hospitalization, by signing the releases section of the camp application.

Camper Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Medical Assistance/I.D. # \_\_\_\_\_ Insurance #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurer's Name: \_\_\_\_\_

I examined this individual on \_\_\_/\_\_\_/\_\_\_\_. Wisconsin Badger Camp requires **annual exams**. ALL exams must be completed on this form and returned to camp *three weeks before camp attendance*. **Medical Exams completed on any other documentation will NOT be accepted.**

BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Free of Communicable Disease as of \_\_\_\_\_

### Description of any camp activity restrictions:

Strenuous Exercise/Physical Activity:

Hiking:

Swimming:

Other Restrictions:

Blood/Body Fluid Precaution: (circle one) Yes / No | If yes, Type: \_\_\_\_\_

Non-Drug Allergies (please explain reaction): \_\_\_\_\_

Drug Allergies (please explain reaction): \_\_\_\_\_

Does this person have a history or experienced seizures or convulsions? \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

Type of seizures: \_\_\_\_\_ Frequency: \_\_\_\_\_

At what point do we call EMS? \_\_\_\_\_

Additional information regarding seizures: \_\_\_\_\_

**THIS FORM IS TO BE RETURNED NO LATER THAN THREE WEEKS PRIOR TO ATTENDANCE.**

Has this person been immunized against the following? If so, the most recent date,

MMR #1 \_\_\_\_\_ MMR #2 \_\_\_\_\_ Tetanus \_\_\_\_\_ Pertussis \_\_\_\_\_ TB Skin Test \_\_\_\_\_

Hep B Vaccine #1: \_\_\_\_\_ Hep B Vaccine #2: \_\_\_\_\_ Hep B Vaccine #3: \_\_\_\_\_

**If not immunized for tetanus in the past 10 years, please do so prior to attendance.**

Is the following normal? If abnormal, please Explain.

Is there a history of the following? If yes, explain.

Normal	Abnormal	Explanation	History	No History	Explanation
		Ears			Asthma
		Nose			Hernia
		Throat			Kidney Disease
		Skin			Diabetes
		Eyes			TB
		Scalp			Hepatitis
		Heart			Heart Disease
		Lungs			Freq. Colds
		Extremities			Stomach Disorders
		Abdomen			Previous Surgery
		Varicosities			Recent Illness
		Genitalia			Other
		Neurologic			

Further recommendations for camp medical staff (current health conditions requiring additional attention, treatment, or special considerations while at camp): \_\_\_\_\_

*I have examined the herein named individual and have reviewed the health history and find this person to be free of any contagious disease. I find this individual able to participate in a camp experience with the previously listed limitations.*

Signature of Licensed Medical Personnel

Date

Printed Name

Title

Address

Phone

Fax

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