



**Page 2 Medical Form-Camp Krem**  
**4610 Whitesands Court**  
**El Sobrante, CA 94803**  
**Phone number: (510) 222-6662**  
**Fax number: (510) 223-3046**

Camper Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

**PHYSICAL EXAM: DOCTOR MUST COMPLETE AND SIGN :** Doctor please review above medication and allergy lists for accuracy before signing.

Because we are a camp for people with developmental disabilities, **YOU MUST LIST WHAT THE CAMPER'S DEVELOPMENTAL DISABILITY AND ANY MEDICAL DIAGNOSIS ARE:**

Developmental Disability: \_\_\_\_\_

Medical Diagnosis 1: \_\_\_\_\_

Medical Diagnosis 2: \_\_\_\_\_

Medical Diagnosis 3: \_\_\_\_\_

Please list any further medical diagnoses on separate page.

Blood Pressure \_\_\_\_ / \_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Temp \_\_\_\_ Pulse \_\_\_\_ Resp: Implants? Yes/No: Type \_\_\_\_\_

**All TB tests must be within 12 months of camp ending date. If PPD not indicated, please initial below.**

PPD neg/pos date \_\_\_\_\_ **OR** This camper is not at risk and/or shows no symptoms of tuberculosis.

Therefore a PPD is not necessary. **MD INITIALS** \_\_\_\_\_

Sleep Machine? Yes/No: Type \_\_\_\_\_

List Any Allergies: \_\_\_\_\_ History of Seizures Yes/No

Type of Seizures \_\_\_\_\_ Date of last seizure: \_\_/\_\_/\_\_\_\_

Frequency and duration \_\_\_\_\_

Please describe camper's seizure activity/when to call MD or parent.

\_\_\_\_\_

Medically prescribed meals or dietary restrictions? \_\_\_\_\_

Recent Health Problems \_\_\_\_\_

\_\_\_\_\_

SYSTEM	NORMAL	ABNORMAL	DESCRIBE
EYES			
EARS			
NOSE/THROAT			
SKIN			
CARDIOVASCULAR			
REPIRATORY			
ABDOMINAL			
NEUROLOGICAL			
MUSCULOSKELETAL			

**STATEMENT OF PHYSICIAN:** I examined camper \_\_\_\_\_

on \_\_\_\_/\_\_\_\_/\_\_\_\_ and found no evidence of communicable disease and found him/her to be in satisfactory condition to participate in camp programs to:

A: \_\_\_\_ FULL EXTENT WITHOUT RESTRICTIONS B: \_\_\_\_ With restrictions \_\_\_\_ Please list restrictions/reasons for restrictions \_\_\_\_\_

I have reviewed camper's medications listed on Page 1 of Medical Form (if camper is prescribed medications).

\*\*\*DOCTOR SIGNATURE \_\_\_\_\_ DATE SIGNED \_\_\_\_\_

OFFICE PHONE (\_\_\_\_) \_\_\_\_\_ MD ADDRESS \_\_\_\_\_