SUMMER AT AIS PHYSICAL EXAMINATION FORM

Student Name_____ D.O.B_____
Upcoming Fall Grade_____
Address_____ Home Phone_____

REQUIRED IMMUNIZATIONS
All campers must complete in full. Please use grid or attach copy of immunization record.

Age appropriate dose of MCV and Tdap are required for rising 7th graders.
**Campers entering Pre-K, K, or Grade 1 for the first time, or entering school in the State of Pennsylvania for the first time, must have a tuberculin test within six months prior to admission to camp, and Grade 9, as per physician discretion.*

VACCINE	DOSES: ENTER MONTH, DAY, AND, YEAR EACH IMMUNIZATION WAS GIVEN				
Diphtheria and Tetanus (DtaP,DTP,Td or DT)	1. / /	2. / /	3. / /	4. / /	5. / /
Tetanus, Diphtheria and Acellular Pertussis (Tdap)*	1. / /	2. / /	3. / /	4. / /	5. / /
Hepatitis B	1. / /	2. / /	3. / /	4. / /	5. / /
Measles-Mumps-Rubella (MMR)	1. / /	2. / /	Or Measles Serology: Date	Titer	
Varicella (vaccine or disease)	1. / /	2. / /	Rubella Serology: Date	Titer	
Polio (OPV or IPV)	1. / /	2. / /	3. / /	4. / /	5. / /
Meningococcal (MCV)*	1. / /	2. / /	Mumps disease diagnosed by a physician: Date		
Other	1. / /	2. / /			

TUBERCULIN TEST DATE:_____ RESULT: _____

Physician Verification_____

CURRENT HEALTH CONDITIONS

	YES	NO	If Yes, Explain:
Allergies	☐	☐	_____
Epinepherine needed?	☐	☐	
Permission to self-carry?	☐	☐	
Permission to self-administer?	☐	☐	

**Campers with epinephrine must provide 2 unexpired pens, Benadryl, and action plan.*

Asthma	☐	☐	_____
Carries inhaler?	☐	☐	_____
Independent on inhaler self-administration?	☐	☐	
Cardiac	☐	☐	_____
Diabetes	☐	☐	_____
Gastrointestinal Disorder	☐	☐	_____
Respiratory Illness	☐	☐	_____

	YES	NO	If Yes, Explain:
Hypertension	☐	☐	_____
Neuromuscular Disorder	☐	☐	_____
Seizure Disorder	☐	☐	_____
Current Medications	☐	☐	_____
Other (chronic physical or emotional conditions)	☐	☐	_____

PHYSICAL EXAMINATION
A thorough health history should be completed prior to the exam.

Date of Examination _____
Student Name _____ D.O.B _____ Grade _____
Height _____ Weight_____ BMI # _____ / _____ %_____ % Body Fat (optional)_____
Is this BMI in recommended range? ☐ Yes ☐ No Was counseling initiated? ☐ Yes ☐ No
Pulse _____ BP _____ / _____ (_____ / _____ ,_____ /_____)
Vision R 20/ _____ L 20/ _____ Corrected: ☐ Yes ☐ No Pupils: ☐ Equal ☐ Unequal

	NORMAL	ABNORMAL FINDINGS	NOT EXAMINED
MEDICAL			
Appearance	☐	_____	☐
Eyes/Ears/Nose/Throat	☐	_____	☐
Lymph Nodes	☐	_____	☐
Heart – Murmur, etc.	☐	_____	☐
Pulses	☐	_____	☐
Lungs – Adventitious Finding	☐	_____	☐
Abdomen	☐	_____	☐
Skin	☐	_____	☐
MUSCULOSKELETAL			
Neck	☐	_____	☐
Back (Scoliosis Screening)	☐	_____	☐
Shoulder/Arm	☐	_____	☐
Elbow/Forearm	☐	_____	☐
Wrist/Hand	☐	_____	☐
Hip/Thigh	☐	_____	☐
Knee	☐	_____	☐
Leg/Ankle	☐	_____	☐
Foot	☐	_____	☐

CLEARANCE

- ☐ Cleared for all sports and activities without restrictions
- ☐ Cleared for all sports and activities without restrictions with recommendations for further evaluation or treatment for:_____
- ☐ Not cleared pending further evaluation
  Reason: _____
  Recommendations: _____

Signature of Physician: _____ Signature Date: _____
Print name of Physician: _____