



# 2026 Easterseals Oregon Evans Creek Retreat Physical Exam Form

Camper Name: \_\_\_\_\_ Date of Appointment: \_\_\_\_\_

This form is to be completed by a licensed physician, nurse practitioner, or physician's assistant. A medical examination must be completed within twelve (12) months of participation in camp session. Physicians may provide their own standardized form.

Height _____	Weight _____	Temp _____
EENT _____	Lungs _____	Pulse _____
Heart _____	Abdomen _____	Resp. _____
GU _____	Blood Press. _____	

State the approximate date of occurrence or most recent incident:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Chickenpox _____        | <input type="checkbox"/> Mumps _____          | Allergies _____                              |
| <input type="checkbox"/> Diabetes _____          | <input type="checkbox"/> Ear infections _____ | <input type="checkbox"/> Latex _____         |
| <input type="checkbox"/> Rheumatic Fever _____   | <input type="checkbox"/> Asthma _____         | <input type="checkbox"/> Food allergy _____  |
| <input type="checkbox"/> Measles _____           | <input type="checkbox"/> Rescue inhaler _____ | <input type="checkbox"/> Insect stings _____ |
| <input type="checkbox"/> Hepatitis carrier _____ | <input type="checkbox"/> Seizures _____       | <input type="checkbox"/> Penicillin _____    |
| <input type="checkbox"/> Migraines _____         | <input type="checkbox"/> Shunt _____          | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Sunburn-prone _____     | <input type="checkbox"/> Other: _____         |  |

If the applicant has an allergy, what reaction(s) does he/she have? \_\_\_\_\_

Does this person have a positive diagnostic x-ray for an Atlantoaxial Dislocation Condition? YES NO

The applicant is under the care of a physician for the following medical diagnosis/disability: (Describe any operations of serious illnesses that relate to the participant's condition or care.)

### Vaccinations

Current on all childhood vaccinations except: \_\_\_\_\_ Date of most recent Tetanus vaccine: \_\_\_\_\_  
TB Test read: \_\_\_\_\_ Positive  Negative

### Recommendations & Restrictions for Easterseals Recreational Programs:

In my opinion, the above conditions permits the applicant's participation in an active recreational program. (Circle) Yes No

There are medical reasons for limiting and/or restricting swimming, horseback riding, boating, or sleeping in tents: (Circle) Yes No Limitations are: \_\_\_\_\_

Treatments and diets that are to be continued while participating in Easterseals Oregon's camping program are: \_\_\_\_\_

I have examined the person herein described and reviewed his/her health history. It is my opinion that he/she is physically able to engage in any required activities, except as noted above, and is free of communicable or contagious disease.

Signature of licensed practitioner: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mail completed form too:

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