2019 Camper Health Provider Evaluation

This form is to be filled out by camper's physician or health provider only, not by parent/guardian.
Health providers may substitute this form with their own evaluation form provided all below information is contained within.
Please upload your completed form on your CampDoc profile.
For Questions please email: bethelhorizons@bethelhorizons.org or call: 608-257-3577 ext. 334

Camper First Name ______________________________ **Last Name**______________________________

Male ☐ Femal☐ Date of Birth ______/______/__________ Current Age ______________

Height __________ Weight ____________ Most Recent Exam/Visit Date ______/______/__________

Camper must have had exam within 24 months of attending camp!

Significant Health History

If yes, please provide details

Food Allergy No☐ Yes☐ ______________________________
Other Allergies No☐ Yes☐ ______________________________
Asthma No☐ Yes☐ ______________________________
Sports Injury No☐ Ye☐ ______________________________
Surgeries/Hospitalization ☐o ☐s ______________________________
Other No☐ Yes☐ ______________________________

Physical Exam & Evaluation

Note details below if relevant

Head	Nl- ☐	Abn ☐
Hair/Scalp	Nl- ☐	Abn ☐
Eyes	Nl- ☐	Abn ☐
ENT	Nl- ☐	Abn ☐
Teeth	Nl- ☐	Abn ☐
Neck/Nodes	Nl- ☐	Abn ☐
Chest	Nl- ☐	Abn ☐
Heart/Pulse	Nl- ☐	Ab ☐-
Abdomen	Nl- ☐	Abn ☐
GU/Gyn	Nl- ☐	Abn ☐
Neuro	Nl- ☐	Abn ☐
Spine	Nl- ☐	Abn ☐
Extremities	Nl- ☐	Abn ☐
Skin	Nl- ☐	Abn ☐

Immunizations **Tetanus** (most recent) **Type** ______________________ **Date** _______/_______/ ___________

Evaluation Healthy ☐ Health Issues ☐ ____

Activity Restrictions No ☐ Yes ☐ ____

Medications No ☐ Yes ☐ ____

Behavioral No ☐ Yes ☐ ____

PROVIDER INFORMATION

Provider Name/Address (or stamp):

Provider's Signature____ Date ______________________