

### HEALTH PROVIDER'S REPORT – 2010

**NAME** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_

DATE of most recent health check/Physical Exam \_\_\_\_\_ By: \_\_\_\_\_

**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **BP** \_\_\_\_\_ **P** \_\_\_\_\_ **R** \_\_\_\_\_

**SIGNIFICANT HEALTH HISTORY:**

Allergies?  -No  -Yes - Specify: \_\_\_\_\_

Asthma?  -No  -Yes - Triggers? \_\_\_\_\_

Sports injuries?  -No  -Yes- Specify \_\_\_\_\_

Hospitalizations?  -No  -Yes -Year/Reason? \_\_\_\_\_

Surgeries?:  -No  -Yes - specify \_\_\_\_\_

Other-specify: \_\_\_\_\_

**PHYSICAL EXAM:**

<i>Nl</i>	<i>Abn</i>	<i>Comments</i>
___	___	Head _____
___	___	Hair/scalp _____
___	___	Eyes _____
___	___	ENT _____
___	___	Teeth _____
___	___	Neck/Nodes _____
___	___	Chest _____
___	___	Heart/pulse _____
___	___	Abdomen _____
___	___	GU/Gyn _____
___	___	Neuro _____
___	___	Spine _____
___	___	Extremities _____
___	___	Skin _____

**DIAGNOSIS/CAMPER'S HEALTH STATUS** \_\_\_\_\_

ACTIVITY RESTRICTIONS?  -No  -Yes; Specify \_\_\_\_\_

CAMPER'S MEDICATIONS and/or TREATMENTS TO BE CONTINUED AT CAMP.

BEHAVIORAL, emotional, educational difficulties?  -No  -Yes. Comments:

**IMMUNIZATIONS** (Please attach record). **TETANUS (most recent):** Type \_\_\_\_\_ Date \_\_\_\_\_

**PROVIDER SIGNATURE** \_\_\_\_\_ **Date** \_\_\_\_\_

If form completed by someone else: Signature \_\_\_\_\_ Date \_\_\_\_\_  
Print Name \_\_\_\_\_ Title \_\_\_\_\_

**PRACTICE:** \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax \_\_\_\_\_

<b>RETURN FORM TO CAMPER, or MAIL to: BETHEL HORIZONS, or 312 WISCONSIN AVE. MADISON, WI 53703</b>	<b>FAX to BETHEL HORIZONS @ Madison office: 608-257-4044 Dodgeville/camp: 608-935-0216</b>
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