



PHYSICAL EXAM FORM

Date Received: _____
(for office use only)

IMPORTANT!

Participant (or parent/guardian for participants under age 18) should complete and sign the top section of this form, authorizing the release and transmission of medical information to Camp Mak-A-Dream. Form must then be completed by the participant's physician and returned to Camp Mak-A-Dream as soon as possible. Applications will not be considered until both the Participant Application and Physical Exam Forms have been received by Camp Mak-A-Dream.

NAME / CAMP SESSION Participant Name: _____

Camp session participant is applying for: _____ Date: _____

(See Program Schedule at www.campdream.org for list of sessions, dates and ages)

I give permission for my/my child's physician(s) to provide medical information directly to Camp Mak-A-Dream.

X _____
Participant / Parent-Guardian Signature _____ *Date* _____

Storage and administration of medications will be provided for all participants under the age of 18. If you are over 18, do you need us to assist you in administering your medications? Yes No

Physicians are to complete the remaining portion of the form and return to:

Camp Mak-A-Dream / P.O. Box 1450 / Missoula, MT 59806-1450 / Fax: (406) 549-5933

MEDICAL DIAGNOSIS

Participant Name: _____ Date of Diagnosis: _____

Type of Diagnosis: _____ Primary Site: _____

Other involvement site(s): _____

Treated with (check all that apply): Chemotherapy Radiation Surgery Other _____

List relevant surgeries and dates: _____

Has participant completed therapy? Yes No

If yes, date of most recent treatment: _____ Type of treatment: _____

If no, in the month prior to camp, will participant receive Chemo? Yes No Radiation? Yes No

If treatment or medications are to be administered at camp, please note instructions on next page.

Are participant's immunizations up to date? Yes No If no, please explain: _____

Describe any special condition(s) or care needed while at camp: _____

Describe any physical disabilities, limitations or restrictions: _____

HT: _____ WT: _____ EENT: _____

LYMPH: _____ LUNGS: _____ GU: _____

HEART: _____ ABD: _____ EXT: _____

Other significant findings: _____

