

# CAMP EMPLOYEE HEALTH EXAMINATION FORM

LUTHERANS OUTDOORS IN SOUTH DAKOTA  
Atlantic Mountain Ranch – Klein Ranch – NeSoDak – Outlaw Ranch

(THIS SIDE TO BE FILLED IN BY EMPLOYEE)

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Last                      First                      Initial

Address \_\_\_\_\_

In case of emergency notify \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**HEALTH HISTORY:**

I have had the following illnesses as checked. Mark any recurring or serious illness with date of illness.

Health History	Disease	Allergies
<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Heart Defect/Disease	<input type="checkbox"/> Measles	<input type="checkbox"/> Ivy Poisoning, etc.
<input type="checkbox"/> Convulsion/Fainting Spells	<input type="checkbox"/> German Measles	<input type="checkbox"/> Insect Stings
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mumps	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Bleeding/Clotting Disorder	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other Drugs
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Other	<input type="checkbox"/> Asthma
<input type="checkbox"/> Mononucleosis		<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Psychiatric Treatment		
<input type="checkbox"/> Headaches/Sinus Trouble		

Past operations or serious injuries (dates) \_\_\_\_\_

Disability or chronic or recurring illness \_\_\_\_\_

Dietary modifications or restrictions \_\_\_\_\_

Current medications (prescribed & over-the-counter) \_\_\_\_\_

Activities to be restricted due to health reasons \_\_\_\_\_

Description of any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp \_\_\_\_\_

I have had the following immunizations as checked:

	Check	Date	Comment
Tetanus <b>**important**</b>	_____	_____	_____
Mumps/Rubella	_____	_____	_____
Diphtheria Vaccine	_____	_____	_____
Smallpox Vaccine	_____	_____	_____
Measles Vaccine	_____	_____	_____
Polio Vaccine: 1st inj.	_____	2 <sup>nd</sup> _____	3 <sup>rd</sup> _____ booster _____
Others _____			

Date: \_\_\_\_\_

\_\_\_\_\_  
**STAFF MEMBER SIGNATURE**

OTHER SIDE TO BE COMPLETED BY A LICENSED PHYSICIAN AFTER YOU HAVE COMPLETED THE ABOVE

# PHYSICAL EXAMINATION

TO BE FILLED OUT BY A LICENSED PHYSICIAN

The object of this examination is to determine that the employee:

1. is physically fit to engage in strenuous activities without harm to him or herself.
2. does not have any contagious or infectious condition that could be conveyed to others.

DATE OF EXAM \_\_\_\_\_

**PHYSICAL EXAMINATION:**                      Satisfactory                      Unsatisfactory

POSTURE – general condition \_\_\_\_\_

HEAD and NECK:

Eyes \_\_\_\_\_

Ears \_\_\_\_\_

Nose \_\_\_\_\_

Throat - general condition \_\_\_\_\_

Teeth - general condition \_\_\_\_\_

Tonsils \_\_\_\_\_

CHEST:

Heart - general condition \_\_\_\_\_

Pulse rhythm \_\_\_\_\_

Blood pressure \_\_\_\_\_

LUNGS:

General condition \_\_\_\_\_

ABDOMEN:

Tenderness - organs palpable \_\_\_\_\_

Hernia \_\_\_\_\_

EXTREMITIES:

Deformities \_\_\_\_\_

Veins \_\_\_\_\_

SKIN:

General condition \_\_\_\_\_

Pediculosis \_\_\_\_\_

Ringworm \_\_\_\_\_

Athletes Foot \_\_\_\_\_

Menstruation \_\_\_\_\_

Reactions to Penicillin, other drugs, etc. \_\_\_\_\_

List current or ongoing treatment or medications: \_\_\_\_\_

Any physical or other conditions requiring restrictions on participation in the camp program (describe any restrictions): \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE of Examining Physician**

**Date signed** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Physician's Phone:** \_\_\_\_\_