WITH A LITTLE HELP SUMMER CAMP: PRE-CAMP PHYSICAL
(Physician should not be a member of family)

This section is to be completed by a physician familiar with your neuromuscular condition who can best determine if you are medically and behaviorally appropriate to attend summer camp. This evaluation must take place no more than three months prior to camp. This physical form must be completed and returned at least four weeks before the start of the camp. All sections of the pre camp physical MUST be completed.

Patient's Name: _____ Age: _____

Vital Signs: Height: _____ Weight: _____ Pulse: _____

Resp. Rate (resting): _____ Blood Pressure (Resting, Sitting): _____

General Inspection/Type of Neuromuscular Disease: _____

STATUS, ESSENTIAL FINDINGS, DEVIATING FROM NORMAL

Head	
Eyes/Vision	
Nose	
Mouth/Teeth	
Ears/Hearing	
Neck/Thyroid	
Thorax/Lungs	
Heart	
Abdomen/Hernia	
Skin	
Lymphatics	
Spine	
Extremities	
Emotional Status	

Neurologic Exam: _____

RECOMMENDATIONS AND/OR RESTRICTIONS WHILE AT CAMP

Participation involves group living and activities in an outdoor setting, a high level of physical activity, adaptive sports, and swimming.

Cardiac: _____

Pulmonary: _____

Special Diet: _____

Medication(s) (please specify dosage): _____

Therapy (physical, respiratory, etc.): _____

Swimming: _____

Strenuous Activity: _____

Other: _____

This form is confidential and will only be seen by the Camp Coordinator and Medical Staff.

NOTE TO PHYSICIAN:

1. The above named person wishes to participate as a camper at the WALH Summer Camp.
   In your medical opinion, is camp an appropriate environment for this child? ☐ YES ☐ NO (CHOOSE ONE)

2. I have examined the person herein described and have reviewed his/her health history. Is it your opinion that this patient is medically and emotionally able to engage in camp activities (i.e., daily physical activity and adaptive sports), except as noted on page one?
   ☐ YES ☐ NO (CHOOSE ONE)

If no, please explain:

A PHYSICIAN MUST SIGN AND DATE IN THE SPACES PROVIDED BELOW:

***Physician should not be a member of person's family.**

Physician/Medical Professional's Name (Please Print)	Address
Physician/Medical Professional's Signature	City State Zip
Date	( ) Phone #

Please Mail This Form To: Camp Coordinator, With A Little Help, P.O. Box 320243, Franklin, WI 53132