WITH A LITTLE HELP 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 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 (during Summer Camp) activities in an outdoor setting, a higher 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: ____

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 individual? ☐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**

____	__________________________________
(Please Print) Physician/Medical Professional's Name	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