## "WITH A LITTLE HELP…" INC. CAMP: PRE-CAMP PHYSICAL

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): _____

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: _____

Recent Respiratory Infection? ☐ YES ☐ NO If yes, give details: _____

_____

Recent Hospitalization or Surgery? ☐ YES ☐ NO If yes, give details: _____

_____

**RECOMMENDATIONS AND/OR RESTRICTIONS WHILE AT CAMP**

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

Cardiac: _____

Pulmonary: _____

Therapy (physical, respiratory, etc.): _____

Swimming: _____

Strenuous Activity: _____

Other: _____

**IMMUNIZATIONS**

Polio (OVP) ☐ YES ☐ NO  Hepatitis B (HPV) ☐ YES ☐ NO  Influenza ☐ YES ☐ NO

Pneumococcal ☐ YES ☐ NO  Measles, Mumps, Rubella (MMR) ☐ YES ☐ NO

Diphtheria, Tetanus, Pertussis (DTP) ☐ YES Year: _____ ☐ NO

**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**
**Or scan and email to: cc@walh.org**