

"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 two weeks before the start of the camp. All sections of the pre-camp physical must be completed to attend camp.

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 Dates Received: _____
Diphtheria, Tetanus, Pertussis (DTP): YES NO Year Received: _____
COVID-19: YES NO Date of most recent vaccination: _____

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:
WALH
3214 S Oakhill Ave.
Janesville, WI 53546
Or scan and email to: cc@walh.org