Sertoma Camp Endeavor, Inc.
A Non-Profit Program for the Deaf and Hard of Hearing

Camper Name:_____ Date of Appointment:_____

This form is to be completed by a licensed physician, nurse practitioner, or physician's assistant. The examination must be completed within **6 months** of participation in camp.

Height	Weight	Blood Pressure	Vision
		/	

	Normal	Abnormal	Comments
Skull, scalp, face, neck	☐	☐	
Nose and sinuses	☐	☐	
Mouth	☐	☐	
Throat and tonsils	☐	☐	
Ears	☐	☐	
Eyes	☐	☐	
Lungs, chest, breasts	☐	☐	
Heart	☐	☐	
Abdomen and viscera	☐	☐	
Anus and rectum	☐	☐	
Endocrine system	☐	☐	
G-U system	☐	☐	
Upper extremities	☐	☐	
Lower extremities	☐	☐	
Feet	☐	☐	
Lymphatic glands	☐	☐	
Skin	☐	☐	
Other Musculoskeletal	☐	☐	
Neurologic	☐	☐	
Physhiatric	☐	☐	

Administration of Medication: I hereby authorize a qualified health supervisor at Sertoma Camp Endeavor, Inc. to administer the following medication prescribed for _____ (Camper's name)

Name of medication(s)	Date prescribed	Usage directions

Approval of Other Medications if Needed	Yes	No
Administration of Tylenol is approved?	☐	☐
Administration of Benadryl is approved?	☐	☐
Administration of Kaopectate is approved?	☐	☐
Administration of Milk of Magnesia is approved?	☐	☐
Administration of Pepto-Bismol (contains aspirin) is approved?	☐	☐
Administration of Robitussin is approved?	☐	☐
Administration of Chlortrimeton is approved?	☐	☐
Administration of Ibuprofen/Advil is approved?	☐	☐

RECOMMENDATIONS AND RESTRICTIONS FOR SERTOMA CAMP ENDEAVOR:

There are medical reasons for limiting and/or restricting swimming, horseback riding, canoeing, or other outdoor activities such as hiking, participation in active sports, or sleeping in tents: YES_____ NO_____
Limitations:
_____
_____

Known food allergies, environmental allergies or other types of allergies:
_____
_____

Treatments and diets that are to be continued while participating in Sertoma's camping program:
_____
_____

I have examined this camper and reviewed his/her health history. It is my opinion that he/she is physically able to engage in any required activities, except as noted above, and its free of any communicable or contagious disease.

Signature of licensed practitioner:_____

Printed name: _____

Address:_____

Phone:_____ Date:_____