2025 Easterseals Oregon
Evans Creek Retreat Physical Exam Form

Camper Name: ______________________________ Date of Appointment: ___________________

This form is to be completed by a licensed physician, nurse practitioner, or physician's assistant. A medical examination must be completed within twelve (12) months of participation in camp session. Physicians may provide their own standardized form.

Height	____________________	Weight	____________________	Temp	____________________
EENT	____________________	Lungs	____________________	Pulse	____________________
Heart	____________________	Abdomen	____________________	Resp.	____________________
GU	____________________	Blood Press.	____________________		

State the approximate date of occurrence or most recent incident:

☐ Chickenpox	_______________	☐ Mumps	___________________	Allergies	
☐ Diabetes	_______________	☐ Ear infections	___________________	☐ Latex	_______________
			__________		
☐ Rheumatic Fever	_______________	☐ Asthma	___________________	☐ Food allergy	_______________
☐ Measles	____________	☐ Rescue inhaler	___________________	☐ Insect stings	_______________
☐ Hepatitis carrier		☐ Seizures	___________________	☐ Penicillin	_______________
			______________		
☐ Migraines	_______________	☐ Shunt	___________________	☐ Other:	_______________
☐ Sunburn-prone	_______________	☐ Other:	___________________		

If the applicant has an allergy, what reaction(s) does he/she have?

Does this person have a positive diagnostic x-ray for an Atlantoaxial Dislocation Condition? YES NO

The applicant is under the care of a physician for the following medical diagnosis/disability: (Describe any operations of serious illnesses that relate to the participant's condition or care.)

____

____

Vaccinations

Current on all childhood vaccinations except: __________________ Date of most recent Tetanus vaccine: ____________

TB Test read: __________ Positive ☐ Negative ☐

Recommendations & Restrictions for Easterseals Recreational Programs:

In my opinion, the above conditions permits the applicant's participation in an active recreational program. (Circle) Yes No

There are medical reasons for limiting and/or restricting swimming, horseback riding, boating, or sleeping in tents:

(Circle) Yes No Limitations are: ____

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

____

I have examined the person herein described 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 is free of communicable or contagious disease.

Signature of licensed practitioner: _________________________________ Date: __________________

Printed Name: ________________________________ Phone Number: ___________________________

Mail completed form too:

Easterseals Oregon Camp Coordinator | 237 NE Broadway, Suite 100, Portland, OR 97232

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