Physical Health Examination

BOUNCE to a healthy you
2016 Summer Program

This form must have been completed within the last two years by a licensed physician or registered nurse.
Must use a separate form for each applicant.

Name of Applicant: _____**Date of Birth:** _____

General Information:
Height _____ Weight _____ BMI% _____ Blood Pressure _____

Immunization History: *(Attach a copy of vaccination records)*
DPT _____ MMR _____ Heptavax (Hepatitis B) _____ Polio POV_____
Varicella (chicken pox) _____ Tetanus Booster _____
Tuberculin Test _____ High Risk_____ Low Risk_____

TANNER Stage: _____

Medical Condition	Yes	No	Specify	Medicine	Dosage
Allergy				EPI-Pen? Y/ N	
Asthma				Inhaler? Y/N	
Head Aches					
Diabetes				Insulin Pump/Coverage at Program	
Cerebral Palsy					
Physical Handicaps					
Recent or Recovering Fractures					
ADD/ ADHD					
Autism					
Down Syndrome					
Seizures					
High/ Low Blood Pressure			Which one?		
Other Comments :					

SEE REVERSE SIDE

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Special Diet / Food Allergies: _____

Medications (list all those currently taking):_____

_____

Specify, if any restrictions on physical activities (i.e. swimming, diving, running, sun exposure, climbing):

_____

Physician Authorization

I have examined the person herein described and have reviewed her health history. It is my opinion that she is physically able to engage in an active summer program.

Signature of Examining Physician:_____Date:_____Phone:_____

Address: _____