Summer Arts at The Cambridge School of Weston - 2018 International Creative Arts Program

Physical Exam Form

To be completed by licensed health care provider in English. This form must be submitted to Summer Arts at CSW by May 1st 2018

Date of Examination ________________________________ (must be on or after 6/26/2016)

Name____ Male Female Date of Birth_____________________________

Health Issues (past or present; please use reverse side if remarks require additional space):

Y N

☐ ☐ Allergies: Please list: Medications ___________________Food _______________ Other _____________________________________

☐ ☐ History of Anaphylaxis to __________________ EpiPen ® or equivalent: Yes ☐ No ☐ ***If yes, please describe:***

____

☐ ☐ Asthma: Inhaler Yes ☐ No ☐ ***If yes, please detail history/treatment:***

____

☐ ☐ Diabetes: Type I ☐ Type II ☐ Insulin Yes☐ No ☐ ***If yes, please detail history/treatment:***

____

☐ ☐ Seizure disorder: ____________________________ ***If yes, please detail history/treatment:***

____

☐ ☐ Chicken Pox Disease ***If yes, Date:*** _____________________________

☐ ☐ Neurological or Psychiatric Illness ***If yes, explain:***

____

☐ ☐ History of diagnosed concussion or traumatic head injury ***If yes, explain:***

____

☐ ☐ Other illness ***If yes, explain:***

____

____

Medication list: please list all current medications taken daily or on as as-needed basis, prescription or non-prescription:

____

____

Physical Examination:

Height: ______ Weight: ______ BMI: ______ BP: ______ P: ______

(check √ = Normal/If abnormal, please describe.)

General____________________ Lungs_____________________ Extremities_____________________

Skin______________________ Heart_____________________ Neurological____________________

HEENT_____________________ Abdomen__________________ Other _________________________

Dental/Oral_________________ Genitalia__________________

Screening:

Vision: Right Eye _________ Left Eye _________ Wears Glasses ________ Contacts _________

Laboratory Test Results (if applicable): ____ Date ____________

The entire examination was normal and this camper/staff member can participate fully in camp programs, activities and contact sports:

Yes ____ No _____

If no, please explain:

____

Tuberculosis Screening (TB) - **All international campers and staff must provide TB screening results within last 6 months.*

PPD-Mantoux skin test OR IGRA test:

Date ___________________ Result___________________

Chest X-ray (Required if PPD result is > 10 mm induration OR positive based on risk factors OR history of positive TST/IGRA)

Date ________________ Result ____________________

Name/Signature of Physician ____________________________Date _____________ Stamp

Address____

Telephone (______) ____________________ Fax (_______) ___________________

Email _____________________________________

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