BOYS & GIRLS CLUBS
OF NEW ROCHELLE

Report of Medical Exam
By Private or Clinic Physician

Complete Medical Exam needs to be done.
Copy of immunization records only is not acceptable!

Name:________________________________Date of Exam:_____/_____/______Grade________

Date of Birth:_____/_____/______ Gender: [ ] M [ ] F School:_____________________________

Ht._____In. Wt._____lbs. BP______/______Hct.________% or Hgb_________U/A__________

Vision: R_____L_______Hearing: R____L____Scoliosis:[ ] Not Present Lead:_______________
[ ] Present

Serious Illnesses, surgery or injuries since last report:_____________________________________
____

Allergies:_________________________________Current Medications:_______________________

Physical Activity: [ ] Unrestricted [ ] Restrictions____

COMPLETE PHYSICAL EXAMINATIONS INCLUDING:
Nutritional status, Skin, Scalp, Hands, Feet, Eyes, Ears, Nose, Teeth, Tonsils, Lymph Nodes, Thyroid Gland, Heart, Lungs, Breasts, Abdomen, Genito-Urinary, Hernia exam, Neurological, And Emotional status is normal except as indicated below:

Immunizations not previously reported to the CSDNR:

	1	2	3	4	5
DPT/DT					
Pollo*					
Hib					
MMR					
Hepatitis B					
Chicken Pox					
Haemophilus Influenzae B					
Other					

*Please note if IPV
PPD Date planted:_____/____/_____Date Read______/_______/______
Reaction: neg. or________x______mm.
If + reaction: [ ] New Converter [ ] Previously treated with: ___________________________________
[ ] History of BCG

CXR: Date of exam:_______/_______/__________Result:____

________________________ ________________________
Signature of Physician **Date**

Physician Name___________________________________Tel #____________________________________

Address____
(may use stamp for address and Tel #)

PLEASE NOTE: NO CHILD, UNDER ANY CIRCUMSTANCES, WILL BE ALLOWED TO ATTEND CAMP UNLESS THIS FORM IS COMPLETED AND RETURNED. THIS IS FOR THE SAFETY OF ALL CAMPERS.