Physical Examination Form Instructions

1. Print and ask your Health Care Provider to complete the attached Physical Examination Form
2. Fax or mail a copy of the completed Physical Examination Form to the Kinney Center by June 1, 2012

Fax: 610-660-2175

Mail: Kinney Center
Saint Joseph's University
5600 City Avenue
Philadelphia, PA 19131
PHYSICAL EXAMINATION FORM (TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER)

Participant’s Full Name: ________________________________

Date of Birth: _____/_____/____

BP: ______/______          HEIGHT: ______ inches          WEIGHT: ______ lbs

VISUAL ACUITY: Right 20 / ______ Left 20 / ______

Medication Allergies: ____________________________________________________________

____________________________________________________________________________

Other Allergies: _________________________________________________________________

____________________________________________________________________________

Current Medications*: __________________________________________________________

____________________________________________________________________________

*if medications must be administered during the camp day, a physician’s order is required

Cardiac, Respiratory or Other Conditions Requiring Special Attention: _______________

____________________________________________________________________________

____________________________________________________________________________

Emergency Treatments (epi-pens, rescue inhalers, etc): _____________________________

____________________________________________________________________________

____________________________________________________________________________

Physical Limitations: ____________________________________________________________

____________________________________________________________________________
### Clinical Evaluation

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Skin</td>
<td></td>
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<tr>
<td>2</td>
<td>Head, Ears, Eyes, Nose, Throat</td>
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<tr>
<td>3</td>
<td>Mouth, Teeth, Gums</td>
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<tr>
<td>4</td>
<td>Neck and Thyroid</td>
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<tr>
<td>5</td>
<td>Lungs/Chest</td>
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<tr>
<td>6</td>
<td>Breasts</td>
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<td>7</td>
<td>Heart</td>
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<tr>
<td>8</td>
<td>Abdomen</td>
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<tr>
<td>9</td>
<td>Genitalia</td>
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<tr>
<td>10</td>
<td>Back/Spine</td>
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<td>11</td>
<td>Extremities / Musculoskeletal</td>
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<td>12</td>
<td>Neurologic</td>
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<td>13</td>
<td>Emotional/Psychological</td>
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<tr>
<td>14</td>
<td>Other Findings</td>
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</tbody>
</table>
Immunization Record

1. MMR (measles, mumps, and rubella):
Immunization with two doses of MMR, given on or after first birthday and separated by at least one month.
Date 1:   
Date 2:   

2. TETANUS/DIPHTHERIA/PERTUSSIS:
Three doses of tetanus/diphtheria/pertussis are required with a booster given within the past ten years.
Date 1:   
Date 2:   
Date 3:   
Tdap Booster:   

3. POLIO:
Three doses; Booster only if needed for travel.
Date 1:   
Date 2:   
Date 3:   

4. VARICELLA VACCINE (Chicken Pox):
Two properly spaced doses of varicella vaccine, laboratory evidence of immunity or reliable history of varicella.
Hx of Disease:  }
   ☐ Yes  ☐ No

Date 1:   
Date 2:   

5. TUBERCULOSIS TESTING/PPD
Date:   
☐ Neg  ☐ Pos

6. OTHER REQUIRED OR RECOMMENDED IMMUNIZATIONS


Physical Examination Form

The above-named patient has my permission to participate in the Kinney Center programs.

______________________________________________
Physician's Name (print)

______________________________________________        ______________________________
Physician's Signature*                        Date

*Please stamp/affix business card to this form