Upward Bound Camp

40151 Gates School Road, Gates OR 97346
Phone (503) 897-2447 Fax (844) 448-7665
Email camp@upwardboundcamp.org

OFFICE USE ONLY
Received by: ____________
Date Received: __________

HEALTH DISCLOSURE PHYSICIANS APPROVAL

HEALTH DISCLOSURE / PHYSICIANS APPROVAL MUST BE COMPLETED BY ALL CLIENTS EVERY 2 YEARS..

Registration cannot be confirmed without current Health Disclosure / Physicians Approval on file.

DATE OF EXAM: ______________________________________

PATIENT INFORMATION - TO BE COMPLETED BY PRIMARY CARE PHYSICIAN

Patient Full Name: ____

Birth Date: MM/DD/YYYY ____________________ Gender: ◯ Male ◯ Female ◯ Other

Height: _________ Weight: _________ BMI: _________ Blood Pressure: _________

BP HX: _________ Blood Glucose: _________ Immunizations Current: ◯ Y ◯ N

Date of last Tetanus: _________ Describe nature of disability (if known): ____________

Date of last physician review of medications: Has Current Prescriptions: ◯ Y ◯ N

EMERGENCY CONTACT INFORMATION

First Name:____________________________ Last Name: __________________ Relationship: ________________

Address: ____ City: ______________ State: __________ ZIP: ________

Phone: ______________________ Email: ____

PLEASE NOTE THE FOLLOWING AS BASIS FOR RECOMMENDATIONS/RESTRICTIONS WHILE AT CAMP:

Activities include but are not limited to: overnight sleeping in bunkhouse or tent style sleeping arrangements with others in peer group; large and small group recreational & educational activities in ratios of 1 staff to two-five campers; a wide range of physical activities not limited to fishing, hiking, swimming, paddle boating, arts & crafts, drama, music, cooking outside, archery, dancing, table games, bowling, basketball, volleyball, nature study & horseback riding. All camp staff possess first aid/CPR training, training in administrating oxygen, AED and epinephrine.

INDICATE SIGNIFICANT FINDINGS / CONDITIONS - TO BE COMPLETED BY PRIMARY CARE PHYSICIAN

Eyes: R________ L________ Ears: R________ L________ Nose/Throat: ______________________

Spine: _____________ Legs: ______________ Feet: ______________ Arms/Wrists: _______ Skin/Scalp:_________

Abdomen: _________ Genitalia: ___________ Chest: _____________ Heart: _____________ Lungs: ____________

Teeth: _____________ General Disposition: ____

Significant Health History: (Swallowing difficulties, heart condition, fragile bones, allergic reactions, asthma, tubes in ears, bleeding/ clotting disorders, chronic UIs, Hepatitis, appendectomy, etc.)

Childhood/Past Illness: ____

Please note any common PRN medication(s) NOT recommended or specifically contraindicated for this patient:

Observations or recommendations for residential care needs: ____________________

Supportive device(s) / equipment needed / recommended: ____________________

Is client currently under the care of a mental health professional? ◯ Y ◯ N If YES-who: ______________

Is client currently under the care of a dentist or orthodontist? ◯ Y ◯ N If YES-who: ______________

Please list past serious injuries / bones / breaks or operations: ____________________

Please list any conditions requiring hospitalization in past ten years: ____________________

◯ I have examined the person herein described on ____________ (date) and have reviewed the health history information provided. It is my opinion that this camper is physically able to engage in camp activities, except as noted: ____

◯ I do not recommend camp attendance: ◯ Y ◯ N

Physician Name Printed: ____ Phone: ________________

Address: ____ City: ______________ State: __________ ZIP: ________

Email: ____

Physician Signature: ____ Date: ________________