

# Joseph Pfeifer Kiwanis Camp

5512 Ferndale Cutoff \* Little Rock, Arkansas 72223

Phone (501) 821-3714 \* Fax (501) 821-2629

Email: camp@pfeifercamp.com

## CAMP PHYSICAL

Return completed form to **Pfeifer Kiwanis Camp**

**About Joseph Pfeifer Kiwanis Camp:** The programs at Pfeifer Camp are very active and strenuous and require that campers be in good physical health. Children with asthma who have had an "attack" within the last year are not recommended for our program related to the following environmental conditions: fireplace smoke in cabins and classroom, excessive dust, rainy days and nights, and spring pollen. The camp is 15 minutes away from the nearest medical facility, and campers may be 15 minutes away from the camp infirmary at any given time. Residential campers must have a completed physical on file. Physicals are considered for one year. If you need more specific information about Pfeifer Camp programs, please call 821-3714.

Name of applicant \_\_\_\_\_

BLOOD PRESSURE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ PULSE \_\_\_\_\_ RESPIRATION \_\_\_\_\_ TEMP \_\_\_\_\_

The applicant is under the care of a physician for the following condition(s): \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion, or concussion: \_\_\_\_\_

Does applicant have:	epilepsy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	pediculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	heart murmurs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	tinea lesions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	scabies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

### **Recommendations and Restrictions while at Camp:**

Any treatment to be continued at camp: \_\_\_\_\_

Any medication to be administered at camp (specific dosages): \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions: \_\_\_\_\_

Any allergies (food, drugs, plants, insects, etc.) Please describe reaction and management of the reaction: \_\_\_\_\_

**In my opinion, the above named applicant is free from communicable diseases and clear of any condition that would prevent his/her participation in an active camping program.**

**LICENSED PHYSICIAN'S SIGNATURE** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Date of Examination** \_\_\_\_\_ **By** \_\_\_\_\_

**THIS FORM MUST BE SIGNED BY A LICENSED PHYSICIAN OR NURSE PRACTITIONER.**