True Friends
10509 108th St. NW
Annandale, MN 55302
registration@truefriends.org
952.852.0101

FOR OFFICE USE ONLY:
Date Rec'd._____
Session_____

PHYSICAL EXAMINATION

This Physical Examination form must be completed and *signed by a Licensed Physician*. We request this form or a copy of a physical dated no later than **12 months** from your camp date ***be received in our office, at least one month prior*** to participation in any True Friends program.

Name:_____Date of Birth____/____/____ Male____ Female____
Last First Middle Initial

Diagnosis:_____
Is any condition present, which may result in an emergency? Please describe:_____
_____

Allergies:_____

EXAMINATION COMPLETED BY DOCTOR

Height: Weight:	Ideal Body Weight:
Pulse: BP: Temp:	Lungs:
Head/Scalp:	Cardiac:
Eyes:	Upper Extremities:
Vision:	Lower Extremities/Edema/Circulation:
Ears/Hearing:	Back/Spine:
Mouth/Throat/Nose:	Perineum:
Neck/Thyroid & Lymph Sys:	Skin:
Nervous System/Pupil Reaction/Reflexes/Gait/Sensations:	Breast Exam: Pap Smear Performed: Testes Exam:
Abdomen:	Free from communicable disease: YES / NO

PREVIOUS ILLNESS (give age when these occurred): Chicken Pox_____ Measles_____
Mumps_____ Scarlet Fever_____ Other_____

IMMUNIZATION HISTORY: Please give dates (month/year) of immunizations and most recent booster dates:
(DPT)_____ MMR_____
Polio_____ Smallpox_____ TB test_____
Influenza_____ Hepatitis b series ____,____,____ Tetanus Booster **(required)**_____

Is client currently receiving: Physical Therapy_____ Speech Therapy_____ Psychological Therapy_____
Other Therapy_____ (please describe):_____

ACTIVITY RESTRICTIONS:
List any conditions, operations or known serious injury that may affect activity level:_____
Are there medical reasons to restrict this person from participating in an overnight camp out? (i.e. sleeping in a tent or on the ground?)
No_____ Yes_____ if Yes, please explain_____
Are there medical reasons to limit or restrict this individual from participating in the swimming program?
No_____ Yes_____ if Yes, please explain_____
Are there medical reasons to limit or restrict this individual from participating in the horseback riding program?
No_____ Yes_____ if Yes, please explain_____
Please list any other activity restrictions while individual is participating in a True Friends service.
_____
Does applicant require daily skilled nursing care? No_____ Yes_____
In the past year, has client's health status changed? No_____ Yes_____ If Yes, please describe_____

Is this client on medication? No____ Yes____
Please list any routine medications NOT necessary during the service period:_____

Please provide a current copy of the individual's medication list with the completion of the physical examination form.

Examining Physician's Name (please print)_____
Signature_____Date_____
Address_____Phone (_____)_____
City/State/Zip_____

In event of illness or injury occurring after this physical report, a descriptive note written by the caregiver or physician must be sent to True Friends prior to participant's arrival. Forms are available on our website at www.truefriends.org