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 to ***be received at the time of applying for 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 on the reverse side of this 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.

MEDICATION LIST

Medication	Dosage	Instructions For Use

Examining Physician's Name (please print) _____

Physician Signature _____

Date _____