



CAMP RISING SUN – STAFF PHYSICAL FORM

(This page is to be completed by CRS staff member)

Staff Member Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Please indicate any of the following (please explain if appropriate):

- | | | |
|--|-----------------------------|-------------------------------------|
| ▪ Neurological Problems (i.e. seizures) | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Respiratory Problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Cardiac Problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Gastrointestinal Problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Genitourinary Problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Muscular Problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Vision Problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Hearing Problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Skin Problems or Rashes | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Allergies (including foods, medications,
insect stings & hay fever) | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |

Immunization History: State requirement for camp. Information must be kept up-to-date.

Ok to provide immunization records in place of completing. Indicate "NA" where not applicable.

- | | | | |
|-------------------|-------------|------------------------------|-------------|
| ▪ DPT Series | Date: _____ | ▪ Last Tetanus Booster | Date: _____ |
| ▪ Tuberculin Test | Date: _____ | ▪ Polio | Date: _____ |
| ▪ MMR | Date: _____ | ▪ Varicella/chicken pox date | Date: _____ |
| ▪ Hepatitis A | Date: _____ | ▪ Hepatitis B | Date: _____ |
| ▪ Hib | Date: _____ | ▪ Pneumococcal | Date: _____ |
| ▪ Influenza | Date: _____ | ▪ Rotavirus | Date: _____ |
| ▪ Meningococcal | Date: _____ | ▪ Other | Date: _____ |

**Proof of measles vaccine must accompany this health form. Please fill in actual dates. Do not check or fill in with "up to date". Tetanus must be within the past 10 years.

Any recent or current infectious/communicable disease exposure? No Yes: _____

Do you have any of the following restrictions? Explain if appropriate:

- | | | |
|--|-----------------------------|-------------------------------------|
| ▪ Diet | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Swimming or Water Sports | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Climbing | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Strenuous Activity | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Contact Sports | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Special Equipment (Glasses, Prosthesis Crutches, etc.) | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |



CAMP RISING SUN – STAFF PHYSICAL FORM

(This page is to be completed by a licensed physician)

Date of Physical: _____ **Physicals must be completed within 2 years of Camp

Patient Name: _____ Date of Birth: _____ Male Female

Height: _____ Weight: _____

▪ Are medications needed at Camp? Yes No

Medication	Strength	Dosage	Form	Frequency

▪ Comments, including condition(s) for which medication(s) are being administered: _____

▪ The applicant is under the care of a physician for the following conditions: _____

▪ Explanation of any reported loss of consciousness, convulsions or concussion: _____

▪ Additional Health Information: _____

*****I have examined the above named person on _____ (date of examination) and have determined that in my opinion, his/her condition allows participation in an active camp program: Yes No**

Physician's Signature: _____ Date: _____

Street Address: _____ City/State/Zip: _____

Phone #: _____ State of Licensure: _____

Please return this completed Medical Form:

Email: registration@camprisingsun.com – Fax: (203) 654-7886 – P.O. Box 472; Branford, CT 06405

MEDICATIONS MUST BE BROUGHT IN THEIR ORIGINAL PHARMACY CONTAINERS