



**Physician Form for:** \_\_\_\_\_ (Name of Camper)

**Must be completed by a physician and sent to Shetek by May 1 to allow adequate time for processing.**

**To the examining physician:** This individual will be attending a one-week camp for People with physical and mental disabilities. Our program provides close supervision over all activities, which may include a fair amount of physical exertion. Your cooperation in completing this examination is very much appreciated.

**Primary Diagnosis** \_\_\_\_\_

**Secondary or Other Diagnosis/Concerns** \_\_\_\_\_

**Allergy Information:** Please list and explain reactions.

Food allergies \_\_\_\_\_

Medication Allergies \_\_\_\_\_

Environmental allergies \_\_\_\_\_

**Immunization History:**

Diphtheria-Tetanus: \_\_\_\_\_ Date: \_\_\_\_\_

Polio Series: \_\_\_\_\_ Date: \_\_\_\_\_

Previous hospitalizations? \_\_\_\_\_ Reasons? \_\_\_\_\_

Past surgeries? If yes, type and dates: \_\_\_\_\_

Is the applicant free of communicable disease?  Yes  No Comment: \_\_\_\_\_

Blood/Body fluid precaution beyond universal precautions?  Yes  No If yes, type: \_\_\_\_\_

<p><b>Physical Examination:</b> Is the following normal? If no, explain:</p> <p>Eyes: _____</p> <p>Nose: _____</p> <p>Ears: _____</p> <p>Throat: _____</p> <p>Heart: _____</p> <p>Abdomen: _____</p> <p>Lungs: _____</p> <p>Extremities: _____</p> <p>Scalp: _____</p> <p>Skin: _____</p> <p>Genitalia: _____</p> <p>Neurologic: _____</p>
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<p><b>Restrictions:</b></p> <p>Diet</p> <p>Swimming</p> <p>Strenuous Exercise</p> <p>Other Restrictions</p> <p><b>Any Further Recommendations?</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Return by May 1 to:** Shetek Lutheran Ministries  
14 Keeley Island Dr.  
Slayton, MN 56172

**Questions?** Phone/Fax: (507)763-3567  
Email: camp@shetek.org