**PHYSICAL EXAM RECORD**

Curiosity Camp requires from your medical provider a record of a physical exam within the last 12 months. Please have your history reviewed by your health care provider and have them fill out the information below. Include copies of any other records you feel pertinent.

Last Name First Name Middle

Date of Birth Date of Examination

Height Weight

Blood Pressure Pulse

Medication Allergies

ACTIVE medical/psychiatric issues:

Significant PAST medical/psychiatric issues:

Current Medications:

|  |  |  |
| --- | --- | --- |
|  |  |  |
| This individual has been prescriber an EpiPen: | YES | NO |
| *If yes, EpiPen form must be completed and returned* | |  |

Please check if normal and explain otherwise.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | HEENT |  | Lungs |  | Spine (Scoliosis) |
|  | Neck |  | Skin |  | Neuro |
|  | Cardiac |  | Extremities |  | Abdomen |
|  | | | |  | GU |

Healthcare Provider Signature: Print Name:

(must be non-family member)

Address:

Phone: Fax:

[**PLEASE RETURN FORM DIRECTLY TO: wellnesscenter@simons-rock.edu**](mailto:PLEASE%20RETURN%20FORM%20DIRECTLY%20TO:%20wellnesscenter@simons-rock.edu)