Camp Putnam, Inc.
PRIVATE PHYSICIAN'S EXAMINATION

Child's Name _____ **Sex:** _____ **Date of Birth:** _____

Address: _____ **Grade:** _____

_____

_____

Immunization	Date	Immunization	Date	Immunization	Date	Special Tests	
				MMR (combined)#1		TB Risk	
DTP		Polio		MMR (combined)#2		Assessment	
						Result	Date
				HepB #1			
				HepB #2			
				HepB #3			
Td		Measles					
		Mumps		Hip #1		Lead Test	
Adult Type		Rubella		Hip #2		Result	Date
Tetanus Toxoid		Varicella		Hip #3			
				Hip #4			
				Other Immunization			

Medical History (give dates)

Accidents		Ear Infections		Measles		Scarlet Fever	
Allergy		Encephalitis		Meningitis		Strep Throat	
Chicken Pox		Rubella		Mumps		Tonsillitis	
Congenital Abnormality		Heart Disease		Operations		Tuberculosis	
Convulsions		Hernia		Poliomyelitis		Whooping Cough	
Diabetes		Kidney Disease		Rheumatic Fever		Other	

Pertinent Family Medical History:

Summary of Significant Treatment Programs Including Current Medications and Suggestions for Program Adjustment, if indicated:

Record Approved by Department of Education and the Mass Department of Public Health

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To ensure a quality standard of complete examination for each child, Please record you findings after each item.

(O) Normal (X) Abnormal

Exam Date:_____

Age:_____BP:_____Pulse:_____Hgt.:_____Wt.:_____

Physical Development:_____Nutritional Status:_____Skin: _____

Eyes: sclera_____pupils_____light & distance: R_____L_____

Ears: canals: R_____L_____drums: R_____L_____

Nose		Septum		Turbinates			
Mouth		Lips		Tongue		Pharynx	
Teeth		Gingiva					
Neck		Mobility		Lymph nodes		Thyroid	
Throat		Shape		Symmetry			
Lungs							
Heart		Rate		Rhythm		Murmur	
Abdomen		Liver		Spleen			
		Hernias					
Ano-Genital		Anus		Penis		Labia	
		Testicles		R		L	
		Tanner Stage:					
Spine		Scoliosis Screening					
		Lower Extremities		Range of motion			
				Development		Strength	
		Upper Extremities		Range of motion			
				Development		Strength	
Cranial Nerve				I-XII			

Gait _____Coordination_____

Lab Tests:

Hgb/Hct_____

Other_____

_____

_____

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Check this box if child has a reliable history of Chickenpox.

Reliable history may be passed on:
*Interpretation of parent/guardian's description of condition.
*Physical examination.
*Laboratory evidence.

Physician's PRINTED name and address:

Date:
Physician's Signature:

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