THEZONE PHYSICIAN EXAMINATION FORM

Please note that the examination must have taken place within the past year.

REFERENCE NUMBER | | | | | | |

TO BE COMPLETED BY PARENT OR GUARDIAN

Last Name | First Name | Middle Name | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* __ __ / __ __ / __ __ __ __

Address | City/Borough | State | Zip Code

TO BE COMPLETED BY HEALTH CARE PROVIDER

Dietary Restrictions
☐ None
☐ Yes *(list)* _____

Does the child/adolescent have a past or present medical history of the following?
☐ Asthma ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
If persistent, check all current medication(s): ☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

Allergies ☐ None ☐ Epi pen prescribed
☐ Drugs *(list)* _____
☐ Foods *(list)* _____
☐ Other *(list)* _____

Explain all checked items on an addendum
☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Other *(specify)* _____

Medications *(if yes please sign medication confirmation form)*
☐ None ☐ Yes *(list below)*
_____
_____
_____

PHYSICAL EXAMINATION
Height _____ cm (__ __ %ile)
Weight _____ kg (__ __ %ile)
BMI _____ kg/m2 (__ __ %ile)
Heart Rate _____ bpm
Blood Pressure _____ / _____ mmHg

General Appearance:

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin	☐ ☐ Psychosocial Development
☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological	☐ ☐ Language
☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine	☐ ☐ Behavioral

Describe abnormalities *(if not enough space please include an addendum)*:

IMMUNIZATION DATES CIR Number of Child

Hep B __ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Rotavirus __ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
DTP/DTaP/DT __ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Hib __ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
PCV __ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Polio __ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __

Influenza __ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
MMR __ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Varicella __ __ / __ __ / __ __	__ __ / __ __ / __ __	
Td __ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Tdap __ __ / __ __ / __ __	Hep A __ __ / __ __ / __ __	__ __ / __ __ / __ __
Meningococcal __ __ / __ __ / __ __	__ __ / __ __ / __ __	
HPV __ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Other *(specify)* _____ __ __ / __ __ / __ __;	_____	__ __ / __ __ / __ __

Allergy Shots

At the suggestion of our doctors, allergy medications should be started about a month prior to camp to facilitate relief during the summer. We will be glad to continue the treatments in camp.

Medication

If the patient will be continuing any medications (including any vitamin/herbal/PRN/over-the-counter) in camp please complete the medication confirmation form (This is besides for the prescription(s) to J Drugs pharmacy)

IMPORTANT

Please make sure that there is an adequate supply of any medication that your patient is taking for the duration of his/her stay in camp. **In addition, please make sure to send prescription(s) to J Drugs Pharmacy in Brooklyn, NY**

Please use this space to write anything else that might be of importance:

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet
☐ Restrictions (*specify*) _____

Follow-up Needed ☐ No ☐ Yes, for _____
☐ Appt. date: __ __ / __ __ / __ __

ASSESSMENT ☐ **Well Child** ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**
_____ __ __ __ __ __
_____ __ __ __ __ __
_____ __ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

Stamp Here
Please make sure all information requested is completed