

**MEDICAL EXAMINATION – To Be Filled Out by A Licensed Physician and Returned To:  
TCDC, 1854 JOSEPH TER., HIXSON, TN 37343 OR FAXED TO (423) 370-1539**

**Campers Name** \_\_\_\_\_ **Campers Date of Birth** \_\_\_\_\_

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Code: √ = Satisfactory    X = Not Satisfactory (explain)    0 = Not Examined

**PLEASE CIRCLE THE APPROPRIATE CODE AND DESCRIBE ABNORMAL FINDINGS**

Eyes	√ X 0	Lungs	√ X 0
Glasses/contacts	√ X 0	Abdomen	√ X 0
Ears	√ X 0	Extremities	√ X 0
Nose	√ X 0	Spine	√ X 0
Teeth	√ X 0	Skin	√ X 0
Throat	√ X 0	Allergy	√ X 0
Heart	√ X 0	Pubertal?	_____ Yes _____ No

Approximate average blood glucose level? \_\_\_\_\_ GlycoHgb \_\_\_\_\_ HgbA1c \_\_\_\_\_

Insulin injection sites? \_\_\_\_\_

If necessary to remove from a pump, or pump failure, what would your insulin preference be? \_\_\_\_\_

What problems, if any, has this patient been having with the management of his/her diabetes?  
\_\_\_\_\_  
\_\_\_\_\_

Other medical history: \_\_\_\_\_  
\_\_\_\_\_

Recommendations and/or restrictions while in camp: \_\_\_\_\_  
\_\_\_\_\_

Describe any known PSYCHOLOGICAL problems, disorders or admissions. Please note any emotional stresses which might impact patient's behavior at camp:  
\_\_\_\_\_  
\_\_\_\_\_

General Appraisal: \_\_\_\_\_  
\_\_\_\_\_

**I UNDERSTAND THAT I AM BEING ASKED TO CERTIFY THAT THE PERSON HEREIN DESCRIBED HAS NO CONTRAINDICATION, WHETHER PHYSICAL, EMOTIONAL, OR MENTAL, FOR PARTICIPATION IN CAMP ACTIVITIES. I CERTIFY THAT, UPON EXAMINATION OF THE PERSON HEREIN DESCRIBED, AND A REVIEW OF HIS/HER HEALTH HISTORY, NO PHYSICAL, EMOTIONAL, OR MENTAL CONTRAINDICATION EXISTS, IN MY OPINION, WHICH WOULD PREVENT SUCH PERSON FROM BEING ABLE TO ENGAGE IN CAMP ACTIVITIES, EXCEPT AS SPECIFICALLY NOTED ON THIS FORM.**

\_\_\_\_\_  
**PHYSICIAN'S SIGNATURE**

\_\_\_\_\_  
Printed Name \_\_\_\_\_ Date of Examination \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_, \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number (\_\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_\_) \_\_\_\_\_