Physical Examination Form Instructions

1. Print and ask your Health Care Provider to complete the attached Physical Examination Form
2. Fax or mail a copy of the completed Physical Examination Form to the Kinney Center by June 1, 2012

   Fax: 610-660-2175

   Mail: Kinney Center
Saint Joseph's University
5600 City Avenue
Philadelphia, PA 19131

Physical Examination Form (To Be Completed By Your Health Care Provider)

Participant's Full Name:____

Date of Birth: ______/_____/_____

BP: _______ /_______ HEIGHT: _______ inches WEIGHT: _______ lbs

VISUAL ACUITY: Right 20 /_______ Left 20 /_______

Medication Allergies:____

____

Other Allergies:____

____

Current Medications*:____

____

____

*if medications must be administered during the camp day, a physician's order is required

Cardiac, Respiratory or Other Conditions Requiring Special Attention:________________

____

____

Emergency Treatments (epi-pens, rescue inhalers, etc):_____________________________

____

____

Physical Limitations:____

____

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For Autism Education and Support

Physical Examination Form

Clinical Evaluation

	Normal	**Abnormal**	**Comments**
1. Skin			
2. Head, Ears, Eyes, Nose, Throat			
3. Mouth, Teeth, Gums			
4. Neck and Thyroid			
5. Lungs/Chest			
6. Breasts			
7. Heart			
8. Abdomen			
9. Genitalia			
10. Back/Spine			
11. Extremities / Musculoskeletal			
12. Neurologic			
13. Emotional/Psychological			
14. Other Findings			

Immunization Record

1. MMR (measles, mumps, and rubella)**:**
Immunization with two doses of MMR, given on or after first birthday and separated by at least one month.
Date 1: _____/____/____
Date 2: _____/____/____

2. TETANUS/DIPHTHERIA/PERTUSSIS:
Three doses of tetanus/diphtheria/pertussis are required with a booster given within the past ten years.
Date 1: _____/____/____
Date 2: _____/____/____
Date 3: _____/____/____
Tdap Booster: _____/____/____

3. POLIO:
Three doses; Booster only if needed for travel.
Date 1: _____/____/____
Date 2: _____/____/____
Date 3: _____/____/____

4. VARICELLA VACCINE (Chicken Pox)**:**
Two properly spaced doses of varicella vaccine, laboratory evidence
Hx of Disease:________ ☐ Yes ☐ No

Of immunity or reliable history of varicella.
Date 1: _____/____/____
Date 2: _____/____/____

5. TUBERCULOSIS TESTING/PPD
Date: _____/____/____ ☐ Neg ☐ Pos

6. OTHER REQUIRED OR RECOMMENDED IMMUNIZATIONS

____

____

____

____

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The above-named patient has my permission to participate in the Kinney Center programs.

____
Physician's Name (print)

______________________________ ____________________
Physician's Signature* Date

*Please stamp/affix business card to this form