

To Be Completed by NYSP Camp Staff & Medical Personnel or Primary Medical Doctor

Camper's Name _____ **Date:** _____

Height _____ in. **Weight** _____ lbs. **Pulse** _____ bpm **Blood Pressure** _____/_____ mmHg

Area Checked	Normal	If Abnormal Describe Here	Follow Up with Parent/Guardian Recommended
Eyes (reflexes, movements, visual acuity)			
Ears (hearing, cerumen)			
Nose, Sinuses			
Mouth, Gums, Teeth			
Neck, Throat			
Skin			
Lungs, Breathing			
Chest			
Lymph Nodes			
Heart			
Abdomen			
Back			
Bones, Joints, Muscles			
Nervous System			

Overall Physical Condition: Child may participate in NYSP Program: Yes No

Any additional comments: _____

Signature of Examining Physician/Medical Personnel

Date