Camp Mak-A-Dream Staff
General Medical Information - Physical Exam Form

Please complete this section of form yourself, then have a medical professional complete the second section. Camp Activities include but are not restricted to: walking, lifting, swimming, sports and rec activities, adventure course, and off campus trips. Return your completed form to:

Mail: Camp Mak-A-Dream / PO Box 1450 / Missoula, MT 59806 Fax: (406) 549-5933 Email: matt@campdream.org

Staff Name (printed): _____

This information and physical form must be complete & returned to Camp Mak-A-Dream prior to your arrival.

Have you ever had chicken pox? (Circle one) Yes No If yes, when? _____
If no, have you had a titer drawn? (Circle one) Yes No What were the results_____

Date of last tetanus booster: _____ Date of last chest X-ray: _____

Current medical conditions/problems (headaches, asthma, seizures, etc.) that could preclude you from participating in or assisting with camp activities: _____
_____

Significant medical history (surgery, injuries, serious illness, etc.) that could preclude you from participating in or assisting with camp activities: _____
_____
Do you have any mental health issues that would prohibit you from fulfilling your duties at Camp?_
(Circle one) Yes No If yes, please explain_____

Allergies (general, medications -prescription and over-the-counter, foods): _____
_____
Are you at risk of anaphylaxis due to the allergy? Yes No If anaphylaxis, are you bringing an epi-pen? Yes No

List any physical restrictions (chronic, acute and/or general) or limitations that would preclude you from participating in camp activities: _____
_____

Name and contact information for physician treating you for condition(s) listed above: _____
_____

List any medications taken regularly (including over the counter): _____
_____

Do you have medical insurance? Yes No If yes, insurance company's name: _____
Policy number: _____
Policy holder's name (if other than your own): _____
Group number (if applicable): _____

Prescription Drug Plan information: _____
Policy number: _____
Phone number: _____

X _____ _____
Staff Member Signature Date

CAMP MĀK-A-DREAM

Information below should be filled out by a physician, physician assistant or nurse practitioner.

General Information:

Staff Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____

Physical Exam Information:

Height _____ Weight _____ BP _____

EENT _____ Lungs _____ Heart _____

Abd _____ GU _____ Skin _____

Additional Information: _____

_____

_____

Restrictions: _____

_____

_____

Camp strongly supports vaccination for staff & volunteer for the safety of the camp community.

Are Patient's immunization up to date? (Circle one) Yes No
(Up to date: age-appropriate vaccinations including MMR, DTaP or Tdap, Varicella or titer test and TB, plus seasonal flu, COVID-19 vaccines)

If no, please explain: _____

Examiner's Signature: _____ Date: _____

Examiner's Information:

Examiner's Printed Name: _____

Medical Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____)_____

Return this completed form to: Children's Oncology Camp Foundation / Camp Mak-A-Dream
P.O. Box 1450 · Missoula, Montana 59806 · Fax (406) 549-5933 · Email: matt@campdream.org
Phone (406) 549-5987 · www.campdream.org