Friendship Ventures
Physical Examination Form

Friendship Ventures
10509 108th St. NW
Annandale MN 55302
Local (320) 274-8376
Metro (952) 852-0101
Fax (952) 852-0123
FOR OFFICE USE ONLY Date Rec'd.______ Session__________

This Physical Examination form must be completed and *signed by a licensed physician*. We request this form or a copy of a physical dated no later than 24 months from your camp date ***be received in our office, at least one month prior*** to participation in any Friendship Ventures service.

Name____Date of Birth____/____/____ Male____ Female____
Last First Middle Initial
Diagnosis:________________________Is any condition present, which may result in an emergency? Please describe:_________________________

EXAMINATION COMPLETED BY DOCTOR

Height: Weight:	Ideal Body Weight:
Pulse: BP: Temp:	Lungs:
Head/Scalp:	Cardiac:
Eyes:	Upper Extremities:
Vision:	Lower Extremities/Edema/Circulation:
Ears/Hearing:	Back/Spine:
Mouth/Throat/Nose:	Perineum:
Neck/Thyroid & Lymph Sys:	Skin:
Nervous System/Pupil Reaction/Reflexes/Gait/Sensations:	Breast Exam: Pap Smear Performed: Testes Exam:
Abdomen:	Free from communicable disease: YES / NO
PREVIOUS ILLNESS (give age when these occurred): Chicken Pox___________________ Measles________________ Mumps__________________ Scarlet Fever_____________________ Other______________________________	
IMMUNIZATION HISTORY: Please give dates (month/year) of immunizations and most recent booster dates: (DPT)___________________ MMR_________ Polio________________ Smallpox____________ TB test____________ Influenza_______ Hepatitis b series ____,____,____ Tetanus Booster **(required)**	

Is client currently receiving: Physical Therapy_____ Speech Therapy_____ Psychological Therapy_____
Other Therapy_____ (please describe):____

ACTIVITY RESTRICTIONS:
List any conditions, operations or known serious injury that may affect activity level:_______________________________

Are there medical reasons to restrict this person from participating in an overnight camp out? (i.e. sleeping in a tent or on the ground?)
No_____ Yes_____ if Yes, please explain____

Are there medical reasons to limit or restrict this individual from participating in the swimming program?
No_____ Yes_____ if Yes, please explain____

Are there medical reasons to limit or restrict this individual from participating in the horseback riding program?
No_____ Yes_____ if Yes, please explain____

Please list any other activity restrictions while individual is participating in a Friendship Ventures program.
____

Does applicant require daily skilled nursing care? No_____ Yes_____
In the past year, has client's health status changed? No_____ Yes_____ If Yes, please describe_________________________
Is this client on medication? No____ Yes____
Please list any routine medications NOT necessary during the service period:_________________________________

Examining Physician's Name (please print)____

Signature_______________________________________Date_________________________Phone (_____)_______________

____
Address City State Zip

NOTE: In event of illness or injury occurring after this physical report, a descriptive note written by the caregiver or physician must be sent to Friendship Ventures prior to participant's arrival.

IMPORTANT NOTICE TO CAREGIVERS

To shorten your check-in time:

1. This form or a copy of a physical dated no earlier than 24 months prior to your camp or respite care date **must be in our office one month prior** to participation in any Friendship Ventures program or service.

2. If there is a change in participant's health or medications, call the director of health care at (952)852-0105. Please keep us updated.

3. We must be notified if the participant has had surgery within three weeks prior to arrival. Please call the Director of Health Care at (952) 852-0105 to determine if we are able to accept the participant.

4. Medications **must** be in **original containers** and **properly labeled** by a pharmacist**.** Non-prescription (over the counter) medications **must** be accompanied by a written order from a doctor.

5. Individuals checking in participants must be able to answer the following questions regarding participants:

   A. Medication and health details.
   B. Special diet details.
   C. Special appliances or other medical needs.

6. A Health Care staff person will be assigned to your participant when you complete the check-in process.

THANK YOU!