



Charles River Rowing Camps
Record of Physician's Medical Examination

Camper's Name _____ D.O.B _____

Street Address _____

City _____ State _____ Zip _____

Immunizations	Primary Series			Boosters		Reactions
	1 st	2 nd	3 rd			
DTP						
Polio						
HIB						
Hep B						
Varicella						
MMR						
PPD						
Influenza						
Lead						

(Name:) _____ was examined by me on (Date :) _____

In accordance with standards of the American Academy of Pediatrics.

Examination revealed the following:

Ht: _____ Wt: _____ BP: _____ Visual Acuity: _____

Illness/Conditions: _____

Medications: _____

Allergies: _____

Deviations from normal: _____

There are no apparent contraindications to full participation in routine or competitive school or camp activities except as noted in the following comments:

Physician's Signature _____, M.D. Date _____

Printed Name _____

Office Address _____

City _____ State _____ ZIP _____

By their signature, the camper's parents declare that he/she has experienced no significant medical problems since the date of the most recent physical exam:

Parent's Signature _____ Date _____

Please return this form by June 1!