



Friendship Ventures Metro (952) 852-0101
 10509 108th St. NW Fax (952) 852-0123
 Annandale, MN 55302 Local (320) 274-8376
fv@friendshipventures.org

FOR OFFICE USE ONLY:
 Date Rec'd. _____
 Session _____

PHYSICAL EXAMINATION

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:
Head/Scalp:		Lungs:
Eyes:		Cardiac:
Vision:		Upper Extremities:
Ears/Hearing:		Lower Extremities/Edema/Circulation:
Mouth/Throat/Nose:		Back/Spine:
Neck/Thyroid & Lymph Sys:		Perineum:
Nervous System/Pupil Reaction/Reflexes/Gait/Sensations:		Skin:
Abdomen:		Breast Exam: _____ Pap Smear Performed: _____
		Testes Exam: _____
		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 service.

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 _____
 Address _____ Phone (____) _____
 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 SHORTEN YOUR CHECK-IN TIME:

1. This form or a copy of a physical dated no later than 24 months prior to your camp date **MUST BE RECEIVED IN OUR OFFICE ONE MONTH PRIOR** to participate in any Friendship Ventures 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 OF ANYONE WHO HAS HAD SURGERY WITHIN 3 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 CONTAINER** and **PROPERLY LABELED** by a Pharmacist.

NON-PRESCRIPTION (OVER THE COUNTER) MEDICATIONS MUST HAVE A WRITTEN ORDER BY A DOCTOR.

5. **PERSONS CHECKING-IN PARTICIPANTS** must be able to answer questions regarding participants:
 - A. Medication and health details.
 - B. Special diet details.
 - C. Special appliances or other medical needs.
6. You will complete the check-in process with the Health Care staff person **ASSIGNED** to your participant.

THANK YOU!

fv@friendshipventures.org

www.friendshipventures.org