



Callahan
INC.

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Quincy, Illinois
62305-5253

CAMP CALLAHAN PHYSICAL FORM

Name _____ Birthday _____ Age _____

Address _____ Zip _____

Home Phone _____ Cell Phone _____

Emergency Contact Person _____ Phone _____

Height _____ Weight _____ Blood Pressure _____

Allergies _____

Medications _____

Glasses YES NO

Does this camper use a breathing/oxygen machine at night? YES NO

Please check if the camper exhibits any problems with-or takes medication for-any of the following:

- | | | | |
|-----------------------------------|--|--|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Heart | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Nervous Condition | <input type="checkbox"/> Incontinence
(daytime) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> COPD | |

Date of Last Tetanus Shot _____

Is there a need to restrict the camper's activities at camp? YES NO

Does the health officer have any concerns or comments regarding this person attending camp?

Doctor's Signature _____ Date _____

Or

Nurse Practitioner's Signature _____ Date _____