

CITY OF LONG BEACH, PARKS, RECREATION & MARINE
PHYSICAL EXAMINATION REPORT

☐ NOT APPLICABLE

Camper

Parent/Guardian Signature

TO BE COMPLETED BY CHILD'S LICENSED PHYSICIAN AND/OR SURGEON:

Blood pressure (MUST be recorded) _____ S _____ D Pulse _____

Please indicate findings for all areas below. Describe in detail all abnormal findings in comments section.

☐ Head

☐ Nose

☐ Chest

☐ Legs

☐ Neck

☐ Mouth

☐ Heart

☐ Abdomen

☐ Eyes

☐ Teeth

☐ Lung

☐ Hernia

☐ Ears

☐ Throat

☐ Arms

☐ Joints

Comments on findings: _____

1. Is there any history of acute or chronic illness? ☐ Yes ☐ No

If yes, please explain in detail _____

2. Is there any history of epilepsy/seizure disorder or unconsciousness? ☐ Yes ☐ No

If yes, please explain in detail _____

3. Is there any history of hospitalization? ☐ Yes ☐ No

If yes, please explain in detail _____

4. Is the child taking any medication or require monitoring on a regular basis? ☐ Yes ☐ No

If yes, please explain in detail _____

Please turn to other side

5. Please check (✓) all activities the child may NOT participate in:

- | | | | |
|------------------------------------|---|--|--|
| <input type="checkbox"/> Badminton | <input type="checkbox"/> Kayaking | <input type="checkbox"/> Street Hockey | <input type="checkbox"/> Basketball |
| <input type="checkbox"/> Pep Squad | <input type="checkbox"/> Swimming | <input type="checkbox"/> Canoeing | <input type="checkbox"/> Roller Hockey |
| <input type="checkbox"/> Tennis | <input type="checkbox"/> Flag Football | <input type="checkbox"/> Sailing | <input type="checkbox"/> Track/Field |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Soccer | <input type="checkbox"/> Volleyball | <input type="checkbox"/> Gymnastic |
| <input type="checkbox"/> Softball | <input type="checkbox"/> Water Activities | <input type="checkbox"/> General Structured Active Games | |

Other (please specify) _____

6. List any restrictions and duration: _____

7. What accommodation(s) would be required in order or the child to participate in any of the programs? _____

LICENSED PHYSICIAN AND/OR SURGEON'S STATEMENT:

I have examined _____ on _____
(Child's name) (Date)

and find that he/she may participate in the Summer Day Camp activities I have indicated.

Signature of licensed physician and/or surgeon (NP must have physician's co-signature) Date _____

Printed name of licensed physician and/or surgeon Date _____

Address, City, State, Zip

I certify that the information provided is true and complete, and I agree to the conditions specified above. I further authorize the City of Long Beach Health Officer to contact my private doctor for the purpose of establishing adequate accommodations.

Signature of parent or legal guardian: _____ Date: _____

The Department of Parks, Recreation and Marine may provide reasonable modification to any department program in accordance with the Disabilities Act of 1990.

FOR OFFICE USE ONLY

I have received this Physical Examination Report.

Supervisor/Day Camp Director

(Date)