



TOWN OF ACTON
472 Main Street
Acton, Massachusetts, 01720
Telephone (978) 264-9608
Fax (978) 264-9630

Nancy McShea
Recreation Director

Dear Youth Summer Program Participant:

Enclosed please find a Physical Examination Form that you need to have completed by your child's physician at least two weeks prior to your child participating in the Town of Acton Youth Summer Program. This is a sample form that we provide. If your physician has a standard form please feel free to submit their form. However, please make sure that the date of the last physical is provided (date of physical must be within one year from the date of the session signed up for), private physician's examination form and immunization records. If you have any questions please feel free to contact the Recreation Department at 264-9608. Thank you for participating in our summer program.

Sincerely,

Nancy McShea
Recreation Director

Town of Acton Summer Program
Health Record
Private Physician's Examination

To Physician/Practitioner:

Child Staff

Name: _____

Address: _____

Date of Birth _____ School _____

Date of last complete physical exam: _____ hgt. _____ Wt. _____

Significant Findings

Blood Pressure _____ / _____

Hct. Or Hgb: _____

Other Lab: _____

TB Test: _____

Significant illness or injuries since last report:

General estimate of health: _____

Immunization/Boosters (give exact date):

DTP: _____

Other: MMR: _____

Td: _____

TOPV: _____

Medication or treatment orders to be carried out at Summer Program:

Restrictions on sports participation or recommended modifications to summer program:

Other Comments:

Signature, Examining Physician/Nurse Practitioner

Name & Address (Please print): _____ Telephone _____

NAME _____

MEDICAL HISTORY (give dates)

Accidents	Ear Infections	Measles	Scarlet Fever
Allergy	Encephalitis	Meningitis	Strep. Throat
Chicken Pox	German Measles	Mumps	Tonsillitis
Congenital Anomaly	Heart Disease	Operations	Tuberculosis
Convulsions	Hernia	Poliomyelitis	Whooping Cough
Diabetes	Kidney Disease	Rheumatic Fever	Other

PERTINENT FAMILY MEDICAL HISTORY

PHYSICIAN'S EXAMINATION

Date _____ (O) Normal (X) Abnormal (Comment: Specify consultation requested)

Age BP/..... Pulse Hgt. Wgt.

Physical Development

Nutritional Status

Skin

Eyes sclera pupils light & distance: r. l. glasses

Ears canals: r. l.

drums: r. l.

Nose septum turbinates

Mouth lips tongue pharynx

Teeth gingiva

Neck mobility lymph nodes thyroid

Throat shape symmetry

Lungs

Heart rate rhythm murmur

Abdomen liver spleen hernias

Ano-Genital anus penis testicles: r. l.

labia

Spine

Lower Extremities range of motion development strength

Upper Extremities range of motion development strength

Cranial Nerve I-XII Gait Coordination

Signature _____