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CAMP/SPORTS/ACTIVITY FORM

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Date of Exam: \_\_\_\_\_

Height \_\_\_\_ / \_\_\_\_ % Weight \_\_\_\_ / \_\_\_\_ % BMI \_\_\_\_ / \_\_\_\_ % BP \_\_\_\_\_ Pulse \_\_\_\_\_

Vision: R \_\_\_\_\_ L \_\_\_\_\_ (with/without glasses) Contacts \_\_\_\_\_

Hearing: R \_\_\_\_\_ L \_\_\_\_\_ Scoliosis Screening \_\_\_\_\_

PHYSICAL EXAM: WNL \_\_\_\_\_

Describe any abnormal findings: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

IMMUNIZATIONS (SEE ATTACHED SHEET)

ACTIVITY FULL \_\_\_\_\_ ACTIVITY LIMITED (see below\*) \_\_\_\_\_

\*EXPLANATION: \_\_\_\_\_

*I have examined this child and have found him/her physically fit to participate in physical education/sports.*

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

DATE \_\_\_\_\_