SETEBAID SERVICES,® INC.
P.O. BOX 196
WINFIELD, PA 17889-0196
(570) 524-9090
FAX: (570) 523-0769

PHYSICAL FORM

The information on this form is not part of the acceptance process, but is gathered to assist our staff in providing the highest quality care. This form is to be completed by a licensed physician and should be based on the patient's most recent exam. Please return the form to the address listed to the right. Thank you.

TO BE COMPLETED BY THE PATIENT

Name: ______________________________ Social Security Number: ☐☐☐-☐☐-☐☐☐☐

Street Address: ______________________________ Date of Birth: ___/___/____ Sex: ❑ *Male* ❑ *Female*

City: ______________________ State: ______ Zip Code: __________ Phone: (_____) ______-______

TO BE COMPLETED BY THE PHYSICIAN OR MEDICAL STAFF

Date of Exam: ___/____/20____ Patient has been in your care since: ___/___/____ Last seen: ❑ *Today* ❑ *Other:________*

VACCINATIONS

Date of Last PPD: ___/___/_____ Results: - + *(explain)*

VACCINE	DATES *(include last booster)*	VACCINE	DATES *(include last booster)*
DPT or DT		MMR	
Polio: ❑ Oral ❑ Injection		HIB	
Hepatitis B		Varivax *(Chicken Pox)*	
BCG		Other *(List)*	

HEALTH HISTORY *(Please check if the patient has had or has any of the following and list any explanations below)*

❑ Frequent Ear Infections	❑ Kidney Disorder	❑ Chicken Pox
❑ Heart Defect/Disease	❑ Sinusitis	❑ Hepatitis
❑ Convulsions	❑ Bedwetting	❑ Measles/German Measles
❑ Diabetes *Type 1* *Type 2*	❑ GI Disturbances	❑ Mumps
❑ Asthma	❑ Psych/Emotl. Disturbances	❑ Other *(List)*
❑ Hypertension	❑ Bleeding/Clotting Disorder	

❑ Allergies: ❑ *Hay Fever* ❑ *Ivy Poisoning* ❑ *Insect Stings* ❑ *Medications/ Other (Please list)*

The patient is under the care of a physician for the following conditions:

Current Treatment Includes:

List any operations or serious injuries and dates:

List any recurring or chronic illnesses/conditions:

Is there anything else in this patient's history of which we should be knowledgeable?

FOR PATIENTS WITH DIABETES

Date of Diagnosis: ___/___/_____ Type: ❑ Type 1 ❑ Type 2 Microalbumin Test Date: __/__/____ Result: ____

Last Glycosolated Hemoblobin Test Date: ___/___/_____ Result: ________ Normal Range:____________________

Medications: *(Please list types, times and dosages)* Insulin(s): Oral:

History of diabetes-related problems: *(i.e. DKA, etc.)*

ALL PATIENTS

Height: ___ ft. ___ in. Weight: _____ lbs. Blood Pressure: ____/____ Pulse: _____

EXAMINATION

Urinalysis	❑ *Satisfactory*	❑ *Not Examined*	❑ *Other*	Eyes/Vision	❑ *Satisfactory*	❑ *Not Examined*	❑ *Other*
Ears/Hearing	❑ *Satisfactory*	❑ *Not Examined*	❑ *Other*	Eye Glasses	❑ *Satisfactory*	❑ *Not Prescribed*	❑ *Other*
Nose	❑ *Satisfactory*	❑ *Not Examined*	❑ *Other*	Throat	❑ *Satisfactory*	❑ *Not Examined*	❑ *Other*
Teeth	❑ *Satisfactory*	❑ *Not Examined*	❑ *Other*	Heart	❑ *Satisfactory*	❑ *Not Examined*	❑ *Other*
Lungs	❑ *Satisfactory*	❑ *Not Examined*	❑ *Other*	Abdomen	❑ *Satisfactory*	❑ *Not Examined*	❑ *Other*
Hernia	❑ *Absent*	❑ *Not Examined*	❑ *Other*	Extremities	❑ *Satisfactory*	❑ *Not Examined*	❑ *Other*
Posture (Spine)	❑ *Satisfactory*	❑ *Not Examined*	❑ *Other*	Genitalia	❑ *Satisfactory*	❑ *Not Examined*	❑ *Other*
Skin	❑ *Satisfactory*	❑ *Not Examined*	❑ *Other*	Other *(Please list)*:			

How may this patient benefit from diabetes camp or a diabetes support program?

Please list any treatments to be continued at the camp/program:

Please list any medications to be administered at the camp/program *(Include name of drug, dosage, frequency/administration times)*:

Please list any medically prescribed dietary restrictions/meal plans:

Please list any restrictions while at the camp/program:

PHYSICIAN INFORMATION

***Please Print** or Stamp*

Physician's Name: ______________________ Phone: ( ) - .

Address: ______________________

City, State and Zip Code: ______________________

Person Completing Form *(if not the physician)*: ______________________ Emergency Phone: ( ) - .

PHYSICIAN SIGNATURE

I have examined the patient described above and have reviewed the health history; it is true and complete as far as I know. It is my opinion that this patient is physically and mentally able to engage in all camp/program activities except where noted above.

Physician's Signature: X______________________ Date: __ __ / __ __ /20 __ __

Copyright © 2007 Setebaid Services®, Inc.