USC TROJAN KIDS CAMP
Pre-Participation Physical Evaluation
Valid for TROJAN KIDS CAMP Participation Only

Activity description:

Trojan Kids Camp is a sports day camp that runs 8:30am-4pm Monday – Friday. Participants learn sport fundamentals, engage in recreational play, and sometimes scrimmage. Depending on the sport, participants may be exposed to outdoor elements for extended periods of time. Please consider nature of activity and environmental conditions when completing the physical assessment and form. *This form must be completed by a physician or designated staff.*

Name: _____ _____
Last Name **First Name**

Date of Birth: _____/_____/_____Sex: M F Height: _____Weight: _____

Temperature: _____ Pulse: _____ Blood Pressure: _____/_____

Vision w/o glasses: (R) _____ (L) _____ Asthma: ☐ Yes ☐ No (Circle one)

Date of last tetanus shot: _____Hemophilia: ☐ Yes ☐ No (Circle one)

	Normal	**If abnormal, describe here**	**Follow-up Yes No**
Ears (hearing absence or cerumen)			
Eyes (reflexes visual acuity)			
Nose, Throat, Sinuses			
Neck			
Lungs			
Breasts			
Lymph Nodes			
Heart			
Abdomen			
Hernia			
Back			
Skin			

Bones, Joints and Muscles			
Nervous System			
Teeth and Gums			

Food Allergies: _____

Drug/Rx Allergies: _____

Current Medication List: _____

_____

Medication(s) Camper will need to take during the camp day (Name, dose, instructions (route, frequency, duration, take with food, storage):_____

_____

**Camper will be allowed to keep rescue medication (Epi-Pen, asthma inhaler) with them on their person during the camp day.*

General Physical Condition: _____

May participate in USC TROJAN KIDS CAMP Program:

☐ Clearance for all sports without restriction

☐ Clearance for all sports without restriction with further recommendation for evaluation or treatment for: _____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports

Reason/Recommendations: _____

_____

Provider's Name:_____(MD/DO/PA/NP) Provider's Phone No.:_____ **Provider's Signature:**_____ **Date:**_____	**Medical Practice Stamp (required)**