TEXAS Department of Assistive and Rehabilitative Services

Division for Rehabilitation Services
Office for Deaf and Hard of Hearing Services

Camp SIGN Camper Medical Information

Contact Information

Applicant name (last name, first name):	Parent or guardian name:
Email address:	Phone number or pager address: ( )
Medicaid or insurance carrier name:	Medicaid or insurance policy number:
Contact person for emergency name:	Phone number or email or pager address:

Medical Information

Immunizations

Attach a copy of the applicant's immunizations record (shot record) to this form. Applicants must show proof of up-to-date immunizations.

Medical Examination

This section must be completed by a licensed physician after reviewing the applicant's medical history with the applicant's parent or guardian.

Date of examination:	Height	Weight
Hearing:	Right ear (decibels)	Left ear (decibels)
Vision	Right eye uncorrected vision	Left eye uncorrected vision
	Right eye corrected vision	Left eye corrected vision

Enter X to complete the following:

The applicant appears to be ☐ well nourished ☐ malnourished ☐ Other, explain:

Enter S for satisfactory, U for unsatisfactory or N for not examined to complete the following:

☐ Nose	☐ Throat	☐ Genitalia	☐ Hernia
☐ Lungs	☐ Skin	☐ Abdomen	☐ Musculoskeletal
☐ Teeth	☐ Heart	☐ General physical and emotional status	☐ Other, explain:

Enter X to complete the following:		
☐ The applicant is in satisfactory condition and may engage in all usual activities. ☐ The applicant is in satisfactory condition and may engage in all usual activities except as noted:		
Licensed physician's first name:		Licensed physician's last name:
Street address:		City:
State:	ZIP code:	Telephone number: ( )
Licensed physician's signature: **X**		Date: