Physical Examination and Health Care Recommendations by Licensed Medical Personnel (MD, PA, or NP)

Name of camp participant _____

Date of examination ____/____/____ (Must be within 12 months of the last day of camp session the camper will be attending.)

BP _____/_____ Weight _____lbs. Height _____ft. _____in.

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

Known Allergies (**essential information**):
Medication/drug: _____
Food and other allergies: _____
Medications to be administered at camp:

Name	Dose	Frequency

Patient abnormal physical findings: _____

☐ In my opinion, the above person is able to fully participate in an active camp program.

☐ In my opinion, the above person is not able to fully participate in an active camp program.

Limitations and/or restrictions placed on activities:

Treatment to be continued at camp:

Medically-prescribed meal plan or dietary restrictions:

Additional information for camp health care staff:

_____ _____
Signature of Licensed Medical Personnel **Date**

_____ _____
Printed Name **Title**

_____
Address

_____
Phone Number