Camper's First Name _____ Last Name _____

Session:_____ Dates:_____ Program:_____

MEDICAL EXAMINATION: To be filled out by licensed Medical Provider. This examination and the date listed below **must be performed within 12 months of the first day at camp.** Examination for some other purpose within this period of time is acceptable. Examination is for determining fitness to engage in strenuous activities. School sports physicals are acceptable.

Date of Exam: _____ Height _____ Weight _____ B.P. _____

(Please indicate yes for satisfactory and no if there are any concerns. Please include explanations of negative responses)

Eyes	_____	Extremities	_____
Glasses	_____	Posture (Spine)	_____
Ears	_____	Skin	_____
Nose	_____	Abdomen	_____
Lungs	_____	Allergy:	_____
Throat	_____	Please Specify	_____
Teeth	_____	Heart	_____

General Appraisal: _____

(For Girls and Women)
Has this person menstruated? ____ If not, has she been told about it? ____ If so, is her menstrual history normal? _____

Special considerations: _____

RECOMMENDATIONS AND RESTRICTIONS WHILE IN CAMP

Special diet _____

Special medicine (name it) _____

Swimming, diving _____

Strenuous activity _____

Other _____

_____

I have examined the person herein described and have reviewed her/his health history. It is my opinion that she/he is physically able to engage in camp activities except as noted above.

Licensed Medical Provider Signature_____ Today's Date _____

Address _____ Phone (____) _____

City, State, Zip _____