PARTICIPATION PHYSICAL

(This part must be completed by a certified and licensed physician, nurse practitioner, or physician assistant.)

Camper Name ______________________ Date of Birth __________________

I have examined the camp participant herein described. Date of examination ______/______/______
(Must be within one (1) calendar year of camp attendance)

Blood Pressure ________________ Weight ___________ Height ___________

The applicant is under the care of a physician for the following conditions: _______________________________________
____

Current treatment at the time of this report includes: ____
____

Recommendations and Restrictions at Camp

Treatment to be continued at camp: ____
____

Medications to be administered at camp (name, dosage, and frequency): _______________________________________
____

Known allergies: ____
____

Any medically-prescribed meal plan or dietary restrictions: ____
____

Description of any limitation or restriction on camp activities: ____
____

Additional information for health care staff at camp: ____

In my professional opinion, the applicant ☐ **IS** ☐ **IS NOT** able to participate in an active camp program.

Signature of Licensed Medical Personnel ____

Printed ____________________________ Title _______________________________ Date _________________

Address ____ Phone ___________________