MEDICAL EXAMINATION by LICENSED MEDICAL PERSONNEL

Name: ____

Date of Birth: ________________________________ ☐ Male ☐ Female

Camp Name: __________________ Session: ____________________

Please have your child's primary healthcare provider complete this form. Once complete, scan and upload the document to your CampDoc.com account or return it to your camp.

Keep the original copy for your own records

ACA accreditation standards require a physical exam within last 24 months

Physical exam performed today? ☐ Yes ☐ No Date: __________________

If "No", date of last physical exam? ______________________________

Height: ____________________________

Weight: ____________________________

Blood Pressure: ____________________________

Conditions List conditions for which the above participant is receiving treatment ☐ None

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Restrictions List activity restrictions ☐ No restrictions

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Past Medical / Surgical History

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Diet / Nutrition List dietary restrictions ☐ Eats a regular diet

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____

Allergies List all allergies and reactions ☐ No known allergies

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Treatments / Medications List treatments/medications to be continued at camp (include name, dose, frequency) ☐ None

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Physician Authorization:

I have reviewed the patient health history form and have discussed the camp program with the patient's parents/guardians. It is my opinion that the patient is physically and emotionally fit to participate in an active camp program (except as noted above).

Address: ______________________________ City: ______________________________

State: __________________ Zip Code: __________ Phone: ______________________________

______________________________ ______________________________

Name of Licensed Provider Signature Date

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