MEDICAL EXAMINATION by LICENSED MEDICAL PERSONNEL

Name: ____

Date of Birth: ________________________________ ☐ Male ☐ Female

Camp Name: ____________________ Session: ______________________

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

____

____

____

____

____

Restrictions List activity restrictions ☐ No restrictions

____

____

____

____

Past Medical / Surgical History

____

____

____

____

Diet / Nutrition List dietary restrictions ☐ Eats a regular diet

____

____

____

Allergies List all allergies and reactions ☐ No known allergies

____

____

____

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

____

____

____

____

____

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

www.campdoc.com

© CampDoc LLC