



**HEALTH EXAMINATION BY PHYSICIAN**

Campers Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Examination: \_\_\_\_\_ Last First Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B/P: \_\_\_\_\_

Disability/Diagnosis: \_\_\_\_\_

Current Treatment: \_\_\_\_\_

Are the following Immunizations up to date:

	Yes	No	
Measles	_____	_____	Date: _____
Mumps	_____	_____	
Rubella	_____	_____	
Chicken Pox	_____	_____	
Hepatitis B	_____	_____	
Diphtheria	_____	_____	
Pertussis	_____	_____	
Polio	_____	_____	
Tetanus	_____	_____	

Does the camper have allergies to medicine? Yes/ No Explain: \_\_\_\_\_

Does the applicant have a seizure disorder? Yes/ No Explain: \_\_\_\_\_

Does the camper take medication? Yes/ No \*\*\*\* If Yes, please complete the **Camper Medication Form**\*\*\*\*

Are there any Restrictions or Recommendations while at camp? \_\_\_\_\_

Are there any Treatments that will need to be followed while at camp? \_\_\_\_\_

**Please use this space to provide any additional information about the campers' behavior, and physical, emotional, or mental health that the camp should be aware.**

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\_\_\_\_\_ This camper may participate in all camp activities  
\_\_\_\_\_ This camper may participate except for: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Print name of Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date Signed