Health Care Evaluation/Recommendations by Licensed Physician

Date of Examination____

In my opinion, _________________________________ 's condition _____does _____does not preclude his/her participation in an active camp program.

Temp________ Pulse________ Resp________ B/P________ Height________ Weight (lbs) ________

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

____

____

Current treatment (include current medications)

____

____

Explanation of any reported loss of consciousness, convulsion or concussion

____

____

Does the applicant have epilepsy? Yes____No _____ Does the applicant have diabetes? Yes_____No_____

Recommendations and Restrictions While at Camp

Any treatment/medications to be continued at camp?

____

Any Medically Prescribed meal plan or dietary restrictions?

____

Any allergies to food, drugs, insect bites, etc?

____

Activities to be encouraged or limited

____

Licensed Physician's Signature___________________________________ **Lic. No** ______________________

Address____

Phone (   )_______________________________________

Date of Form Completion______________________________

***By**____

***Initial if completed by a Nurse or Physician's Assistant**