

Founded in 1927 by  
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## CAMPER MEDICAL FORM

To be completed by Physician

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Problem List: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications and Doses: \_\_\_\_\_  
\_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Allergies: \_\_\_\_\_

Date of last tetanus vaccination: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP \_\_\_\_\_

Indicate if abnormal:

_____ head	_____ lungs
_____ eyes	_____ heart
_____ ears	_____ abdomen
_____ nose	_____ genitalia
_____ mouth	_____ extremities
_____ neck	_____ neurological

Does this person have physical, mental, or medical problems that would limit participation in a summer camp program?

\_\_\_\_\_ yes \_\_\_\_\_ no

If yes, please explain: \_\_\_\_\_

### CERTIFICATION:

I certify that this person may:

- \_\_\_\_\_ not participate in camping activities
- \_\_\_\_\_ participate in routine camping activities
- \_\_\_\_\_ participate in camping activities with restrictions (please list) \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Physician's address and telephone: \_\_\_\_\_  
\_\_\_\_\_