Camper Physician Form
(physician use only)

Camper's Name _____ ☐ Male ☐ Female
First Middle Last

Birthdate _____ Height _____ Weight _____ BP _____
Month/Day/Year

Name of Physician: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

Email: _____

Please Indicate if Abnormal	Yes	No		Yes	No
1. Head	☐	☐	8. Lungs	☐	☐
2. Eyes	☐	☐	9. Hearing	☐	☐
3. Ears	☐	☐	10. Heart	☐	☐
4. Nose	☐	☐	11. Abdomen	☐	☐
5. Mouth	☐	☐	12. Genitalia	☐	☐
6. Neck	☐	☐	13. Extremities	☐	☐
7. Neurological	☐	☐			

Please explain any "yes" answers, noting the number of the questions.

_____
_____
_____
_____
_____

Does this person have physical, mental ,or medical challenges that would limit participation in a summer camp program? ☐ No ☐ Yes

*If you answered "yes" to the question above, please explain.

Certification:

I certify that: (please initial)

_____ this person may **not** participate in camping activities
_____ this person may participate in routine camping activities
_____ this person may participate in camping activities with restrictions(please list)

_____

_____ I have included an up to date **immunization** and **medication record.**

Signature of physician _____

Printed Name _____ Date _____

*Completed forms can be sent to Camp Thorpe, PO Box 82, Brandon, VT 05733

(For camp use only)
Name _____
First Middle Last
Family: _____
Cabin _____