

MEDICAL EXAMINATION by LICENSED MEDICAL PERSONNEL

Name: _____
Date of Birth: _____ Male Female
Camp Name: _____ Session: _____

Please have your child's primary healthcare provider complete this form. Once complete, scan and upload the document to your CampDoc.com account or return it to your camp.
Keep the original copy for your own records

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: _____
State: _____ Zip Code: _____

City: _____
Phone: _____

Name of Licensed Provider

Signature Date