



**MEDICAL EXAMINATION FORM FOR SUMMER CAMP**  
 Please make a copy of this form to keep on file for your own reference.

A medical exam is required within 12 months of the camping session. If an exam was already done within this time period, your physician may be willing to fill out the form without an additional examination. *You may submit a separate Medical Exam/Summary Report from your physician in place of this form if it covers contained information. Check your camp website for the deadline to return this form and any possible late fees.*

Attendee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Session of Camp attending \_\_\_\_\_

**This form must be completed by a licensed Physician (MD or DO), Physician Assistant, or Nurse Practitioner**

I examined this individual on \_\_\_\_\_ BP : \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

**Past Medical History** (Medical, Mental Health, Psychiatric, Learning Disabilities, Sensory Issues, etc.)  Check here if NONE


**Treatments / Medications**  Check here if NO MEDICATIONS

Name	Dose	Frequency

**Activity Restrictions**  NO Restrictions while at camp


**Allergies / Reactions**  No known allergies


**Diet/Nutrition** List dietary restrictions  Eats a regular diet


**Additional information for health care staff at the camp:**


**PLEASE NOTE:** For individuals with severe/anaphylactic allergies, asthma, seizures, diabetes, or other serious medical conditions, there are additional Action Plan forms that are required with more detailed information so that we may adequately care for your child.

In my professional medical opinion, the above applicant  IS  IS NOT able to participate in an active camp program.

**Signature of Physician (MD or DO), Physician Asst. or Nurse Practitioner:** \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

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