HEALTH CARE RECOMMENDATIONS and

PHYSICAL EXAM BY LICENSED PHYSICIAN

Or Nurse Practitioner

Camper Name _____ Birth date _____/_____/_____
Last First M.I.

This portion is to be completed prior to arrival at camp. All information must be completed by authorized personnel.

S = ***Satisfactory*** **N =** ***Not Satisfactory*** **W =** ***Needs Watching***

General Appraisal_____
Feet _____
Skin: Scabies _____
Athlete's Foot _____
Impetigo_____
Eyes: Vision_____
Discharge _____
Glasses/Contacts _____
Nose: Discharge _____
Ears: Hearing_____ Discharge_____

Weight _____lbs ***Height*** _____ inches
BP _____/_____
Throat _____
Teeth _____
Lungs_____
Abdomen_____
Hernia _____
Urine _____
Menstruation_____

• This child is under the care of a physician for the following conditions - Current treatment at the time of this report includes:

_____

_____

RECOMMENDATIONS AND RESTRICTIONS AT CAMP: to be completed by a **LICENSED PHYSICIAN**

• Treatment to be continued at camp - Medications to be administered at camp (name, dosage, frequency):

_____

_____

• Any medically-prescribed meal plan or dietary restrictions:

_____

_____

• Known allergies and management of allergies:

_____

_____

• Description of any limitations or restrictions on camp activities:

_____

_____

• Additional information for health care staff at the camp:

_____

_____

IN MY OPINION, THE ABOVE CHILD ☐ IS ☐ IS *NOT* ABLE TO PARTICIPATE IN AN ACTIVE CAMP PROGRAM

Signature of Licensed Physician_____ **Date**_____

Printed _____ **Title** _____

Address _____

Phone _(_____)_____ **Fax** _(_____)_____