



Camper Name: _____

Date of Birth: _____

Session Start Date: _____

Health Exam Form

Have your Physician or Nurse Practitioner complete this form each year.

Please upload this completed form to your CampDoc account.

Camper's Legal Name: _____ Date of Birth: _____ Date of Medical Evaluation: _____

In my opinion, this person's condition does does not allow his/her participation in an active camp program.

Please describe any restrictions for participation: _____

Current treatment to be continued at camp (include current medications): _____

Explanation of any reported loss of consciousness, convulsion, or concussion: _____

This person is allergic to the following (food, medication, etc.): _____

Treatment for allergic response: _____

Any medically prescribed meal plan or dietary restrictions: _____

Any specific safety considerations (no top bunk, lifejacket required while swimming, weight restrictions camper can carry, necessary medications, etc): _____

Does this person have epilepsy? Yes No

Is this condition able to be controlled by camper? Yes No

Does this person have diabetes? Yes No

Is this condition able to be controlled by camper? Yes No

Does this person have asthma? Yes No

Is this condition able to be controlled by camper? Yes No

Immunization History: Provide the month and year for the tetanus immunization or send print-out from Physician's office.

Date of last Tetanus: _____ I Agree all other immunizations are up to date

We want every camper attending camp to have a safe, fun, and enriching experience. Knowing more about your child helps us achieve this. Does your camper have a mental health status or a recent event you would like us to be aware of? What coping strategies work best for your child? _____

Physician or Nurse Practitioner Signature: _____ Clinic Name: _____

Office Phone: _____ Clinic Address: _____

Date of Form Completion: _____