CAMP HANOVER
EST. 1957

3163 Parsleys Mill Road
Mechanicsville, VA 23111
PHONE: (804) 779-2811
FAX: (804) 779-3056
EMAIL: info@CampHanover.org
WEB: www.CampHanover.org

HEALTH EXAM

This form is to be completed by a licensed healthcare provider - M.D., P.A., or N.P.

A completed Health Exam is required in order to participate in any Camp Hanover program.

Camp Hanover is accredited by the American Camp Association for the safe operation and high quality of our programs. So that we may meet the standards for accreditation, participants are required to provide a record of a health exam by a licensed healthcare provider which attests to the participant's ability to safely participate in the program. The physical exam must have occurred within twenty-four (24) months of a participant's arrival at camp. ***Please bring the completed form with you on Check-in Day.***

GROUP:

TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER

A "licensed healthcare provider" includes licensed physicians (M.D.), physician's assistants (P.A.), and certified nurse practitioners (N.P.) or other healthcare providers licensed by the Commonwealth of Virginia to conduct health examinations.

SESSION:

Participant/Camper Name: _____ (LAST / FIRST / MIDDLE) **BP:** _____ / _____

Date of Examination: _____ / _____ / _____ ***(Must have occurred within 24 months of arrival at camp)*** **Height:** _____ ft _____ in

Date Form Completed: _____ / _____ / _____ **Date of Last Tetanus Shot:** _____ / _____ / _____ **Weight:** _____ lbs

1. Pertinent abnormal medical physical findings:

2. This participant is under the care of a physician for the following conditions:

3. Does the participant have any known allergies? ❑ Yes ❑ No If Yes, please list allergies and treatment below:

4. Will medications be administered to the participant while at camp? ❑ Yes ❑ No If Yes, please list medication, dosage, frequency below:

5. Are any limitations or restrictions placed on activities? ❑ Yes ❑ No If Yes, please list restrictions below:

6. Does the participant have a medically-prescribed meal plan or any dietary restrictions? ❑ Yes ❑ No If Yes, please list restrictions below:

7. Is there any treatment to be continued while at camp? ❑ Yes ❑ No If Yes, please provide treatment instructions below, or attach as separate sheet:

8. Additional information for camp healthcare staff:

NAME(LAST, FIRST):

❑ **In my opinion, the above named participant is able to fully participate in an active camp program**

❑ In my opinion, the above named participant **is NOT able** to fully participate in an active camp program

Signature of Licensed Healthcare Provider: _____ Date: _____ / _____ / _____

Printed Name: _____ Title: _____

Address: _____

Phone: (_____) _____

FOR CAMP USE