PHYSICIAN SIGNATURE FORM

HAVE AN *MD, NP* OR *PA* REVIEW, COMPLETE AND SIGN WITHIN *12 MONTHS* OF CAMP SESSION

Camper Name:____ Gender: ☐ Male ☐ Female

Date of Birth_____/____/______ Age/Grade:________________ Date of Examination:_____/____/_______

Height: ____________________ Weight: ___________________ Blood Pressure: _____________________

Parent/Guardian(s) Name: ____

Relation to Camper: ____

Contact Phone #: (_________)______________________________ May we text you? ☐ Yes ☐ No

Is the camper under care of physician ☐ Yes ☐ No If yes, for the following condition(s): ______________________

____

If yes, Physician Name:_________________________________Contact Info:______________________________

Current Medications, Supplements, Vitamins: (use back of form if necessary): _____________________________

____

Are there any medications the camper cannot take? ☐ Yes ☐ No If yes, what medications: ___________________

____

Allergies to (food, drugs, plants, insects, etc.): ____

____

Dietary restrictions: ____

____

Activity restrictions: ____

____

____

Medical, Emotional, and Social Health History: (use back of form if necessary)______________________________

____

Form Reviewed and Completed by: ____

(PRINT NAME OF MD, NP or PA)

Signature:____ Date of Form Completion:_____/____/_____

Address:____ Phone #: (_______)______________________

____

Pisgah Astronomical Research Institute • 1 PARI Drive • Rosman, NC 28772

Phone: (828) 862-5554 • Fax: (828) 862-5877 • Email: rcobb@pari.edu • Website: www.pari.edu