PHYSICIAN SIGNATURE FORM

HAVE AN *MD, NP* OR *PA* REVIEW, COMPLETE AND SIGN WITHIN *12 MONTHS* OF CAMP SESSION
Follow the directions on the previous page for returning this form to us.

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

Additional Contact Phone #'s: (_________)_____________________ (_________)_______________________

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: ____

____

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)______________________________

____

Reviewed and Completed by: ____
(PRINT NAME OF MD, NP or PA)

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

Address: ____ Phone #: (_______)______________________

____

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