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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