SUMMER 2024

MEDICAL EXAMINATION by LICENSED MEDICAL PERSONNEL

EXAMINATION FOR THIS FORM MUST BE COMPLETED AFTER MAY 1, 2023

Name: ______________________________

Date of Birth:__________ ☐ Male ☐ Female ☐ Non-binary ☐ Not listed__________

Camp Program:____________________ Session: ____________________

Is this camper fully immunized? ☐ Yes ☐ No Most Recent Tetanus ____________

Most Recent Flu ________ Covid vaccination? ☐ Yes ☐ No Most Recent __________

Physical exam performed today? ☐ Yes ☐ No Date: ____________________

If "No", date of last physical exam? ____________________

Weight: ______ Height: ______ BP: ______ HR: ______

ALL Vital Signs within normal limits? ☐ Yes ☐ No

Physical, Mental, Social, Behavioral Health Issues: List all conditions for which the above participant is receiving treatment. ☐ None

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Restrictions: List any activity restrictions ☐ No restrictions

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Past Medical /Mental Health/ Surgical History: ☐ None

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Diet / Nutrition: List dietary restrictions/sensitivities ☐ Regular diet

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Allergies: List all allergies and reactions ☐ No known allergies

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Treatments / Medications: List treatments/medications to be continued at camp (include name, dose, frequency) ☐ None

****ALL MEDICATIONS MUST HAVE A PRESCRIPTION ESCRIBED TO AMAC PHARMACY****

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Licensed Physician/Healthcare Provider Authorization:
I have reviewed the patient health history form and have discussed the camp program with the patient's parents/guardians. It is my opinion that the patient is physically and emotionally fit to participate in an active camp program (except as noted above).

Address: ______________________________ City: ____________________

State: ____________ Zip Code: ____________ Phone: ____________________

Name of Provider: ____________________ Signature: ____________________ Date: __________