**CAMP HOPE PHYSICIAN’S EXAMINATION FORM**

**For New and Returning Campers**

**(TO BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN)**

**\*A COMPLETE MEDICAL/PHYSICAL EXAMINATION AFTER JULY 2024 IS REQUIRED TO ATTEND CAMP\***

**Name of Camper/Patient:**

**I have examined the individual named on this form.**

**Date of last OK examination:**

Height Ears Heart Skin

Weight Nose Lungs Scalp

Pulse Throat Abdom. Spine

BP Eyes Hernia Extm.

**EXAMINATION RESULTS (N=NORMAL)**

Height \_\_\_\_\_\_\_\_\_ Ears\_\_\_\_\_\_\_\_ Heart\_\_\_\_\_\_\_\_\_\_\_\_ Skin\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight \_\_\_\_\_\_\_\_ Nose \_\_\_\_\_\_\_ Lungs \_\_\_\_\_\_\_\_\_\_\_ Scalp\_\_\_\_\_\_\_\_\_\_\_\_

Pulse \_\_\_\_\_\_\_\_ Throat\_\_\_\_\_\_ Abdomen \_\_\_\_\_\_\_\_\_ Spine\_\_\_\_\_\_\_\_\_\_\_\_

**In my opinion, this individual is is not able to participate in all camping activities. They may NOT participate in the following activities:**

**The individual is under the care of a physician for the following reason:**

**Diagnosis(s):**

**MEDICATIONS:**

This individual takes NO prescribed medications on a routine basis.

The following medications are ordered for the person named on this form. (If a person is on ANY medications that will be administered during camp, even Ibuprofen, a prescription must accompany medications. The prescription must specify hour of day for administration (ex. 12:00 PM, not lunchtime). The prescription must also give specific instructions for administration (ex. grind pill, open capsule, take with food, etc.)

**(Over, please)**

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Medication\* Administration Times / Special Instructions

Med # 1

Med # 2

Med # 3

Med # 4

\*If there are additional medications, please attach a separate piece of paper

**Medically prescribed diet:**

**Treatment(s) administered at camp:**

**Known allergies:**

**IMMUNIZATION RECORD (FILL THIS SECTION OUT OR SEND A CHART COPY/PRINTOUT)**

***\*\*UNLESS ACCOMPANIED BY A MEDICAL OR RELIGIOUS EXEMPTION, ALL CAMPERS MUST HAVE A COMPLETED* *IMMUNIZATION RECORD TO ATTEND CAMP.***

Date

MENINGITIS

DTP

TD (TETANUS/ DIPHTHERIA)

TETANUS

POLIO

MEASLES/ MUMPS/ RUBELLA

CHICKEN POX

TB MONTEUX\* results

HEPATITIS

PNEUMOCOCCAL

\*Within 1 year

**Additional information for health care staff at camp:**

**Signature of physician: Date:**

**Name of physician (please print):**

**Address:**

**Phone #**: