Camp Shohola for Boys Camper Medical Examination By Licensed Healthcare Provider

PLEASE HAVE YOUR CHILD'S PRIMARY HEALTHCARE PROVIDER FILL OUT THIS FORM AND SCAN AND UPLOAD IT TO YOUR ONLINE REGIRATION ACCOUNT. KEEP THE ORIGINAL FOR YOURSELF.

Camper Name___________________________________ Height___________________________

Date of Birth_____________________________________ Weight___________________________

Physical Exam Performed Today Yes No Blood Pressure___________________

If No, Date of Last Physical Exam_________________________

Conditions: List any conditions for which camper is receiving current treatment.

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Restrictions: List any activity restrictions:

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Past Medical/Surgical History:

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Diet: Please list any dietary restrictions

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Allergies: List all allergies and reactions

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Treatments/Medications: Please list treatments/medications to be continued at camp. Include name, dose, frequency.

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Physician Authorization: I have reviewed the patient's health history with the parent/guardian. It is my opinion that the patient is emotionally and physically fit to participate in camp activities except as noted above.

Licensed Provider Name_______________________________ Signature_______________________________________

Address: ____ City:____

State:_________ Zip:____________________ Date:____