# 2024 Physician's Form

**(To be completed by Camper's Physician)**

***A current (within 1 year of camp date) health physical direct from your physician's office is preferred, or you may substitute with this form to be completed and signed by your camper's physician.***

Camper's Name:_______________________________________________ Age:_______ DOB: ____/____/____

Parent/Legal Guardian(s) Name: _______________________________________________

Address: _______________________________________________

Phone: Home: ______________________ Work:_________________________ Cell: ____________________________

Camper's Primary Physician: ______________________________________________ Phone: _______________________

Physician's Address _______________________________________________

## General Physical Condition

Height__________ BP_____________ Ears___________

Weight_________ Eyes___________ Lungs__________

Skin: Clear________ Dermatitis __________ Eczema __________ Infections _____________

Date of last Tetanus Shot__________ Is this camper subject to seizures? ____No ____Yes

Known Allergies:_______________________________________________

Should the camper be restricted from any camp activities? _____No _____Yes (specify_________________________________)

## Mental Evaluation

Diagnosis: _______________________________________________

_______________________________________________

Additional Comments:_______________________________________________

_______________________________________________

**Physician's Signature** _______________________ **Print Name** _______________________ **Date** __________

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