



2020 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 use 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