



# 2025 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**