SUMMER 2025

MEDICAL EXAMINATION by LICENSED MEDICAL PERSONNEL

EXAMINATION FOR THIS FORM MUST BE COMPLETED ON or AFTER MAY 1, 2024

Name: ______________________________

Date of Birth:____________ ☐ Male ☐ Female ☐ Non-binary ☐ Not listed_________

Camper Program or Staff:______________________Camper Session(s): ________

Is participant fully immunized? ☐ Yes ☐ No Most Recent Tetanus _______________

Most Recent Flu _________ Covid vaccination? ☐ Yes ☐ No Most Recent ___________

Physical exam performed today? ☐ Yes ☐ No Date: ________________________

If "No", date of last physical exam? ________________________

Weight: ______ Height: ______ BP: ______ HR: ______

ALL Vital Signs within normal limits? ☐ Yes ☐ No

Physical, Mental, Social, Behavioral Health Issues: List all conditions for which the above participant is receiving treatment. ☐ None

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Restrictions: List any activity restrictions ☐ No restrictions

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Past Medical /Mental Health/ Surgical History: ☐ None

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Diet / Nutrition: List dietary restrictions/sensitivities ☐ Regular diet

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Allergies: List all allergies and reactions ☐ No known allergies

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Treatments / Medications: List treatments/medications to be continued at camp (include name, dose, frequency) ☐ None

****ALL CAMPER MEDICATIONS MUST HAVE PRESCRIPTIONS ESCRIBED TO AMAC PHARMACY****

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Licensed Physician/Healthcare Provider Authorization:

I have reviewed the patient health history form and have discussed the camp program with the patient's parents/guardians. It is my opinion that the patient is physically and emotionally fit to participate in an active camp program (except as noted above).

Address: ______________________________ City: ______________________

State: ________________ Zip Code: ________________ Phone: ______________________

Name of Provider: ____________________ Signature: ____________________ Date: __________