

SUMMER 2026

MEDICAL EXAMINATION by LICENSED MEDICAL PERSONNEL

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? _____

EXAMINATION FOR THIS FORM MUST BE COMPLETED
ON or AFTER MAY 1, 2025



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

Restrictions: List any activity restrictions No restrictions

Past Medical /Mental Health/ Surgical History: None

Diet / Nutrition: List dietary restrictions/sensitivities Regular diet

Allergies: List all allergies and reactions No known allergies

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****

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: _____