

SUMMER 2026

MEDICAL EXAMINATION by LICENSED MEDICAL PERSONNEL

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



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

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: _____