

# SUMMER 2024

## MEDICAL EXAMINATION by LICENSED MEDICAL PERSONNEL

EXAMINATION FOR THIS FORM MUST BE COMPLETED  
AFTER JUNE 20, 2023



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female  Non-binary  Not listed \_\_\_\_\_

Camp Program: \_\_\_\_\_ Session: \_\_\_\_\_

Is this camper 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

**Conditions:** List conditions for which the above participant is receiving treatment

None

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**Restrictions:** List activity restrictions

No restrictions

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**Past Medical / Surgical History**

None

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**Diet / Nutrition:** List dietary restrictions

Eats a 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 MEDICATIONS MUST HAVE A PRESCRIPTION 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: \_\_\_\_\_