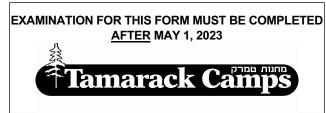
MEDICAL EXAMINATION by LICENSED MEDICAL PERSONN	ΕI



Name:	מחנות טמרק
Date of Birth: □ Male □ Female □ Non-binary □ Not listed	Tamarack Camps
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:	Weight: Height: BP: HR:
If "No", date of last physical exam?	ALL Vital Signs within normal limits? ☐ Yes ☐ No
Physical, Mental, Social, Behavioral Health Issues: List all conditions for w	which the above participant is receiving treatment.
Restrictions: List any activity restrictions No restrictions Pas	t Medical /Mental Health/ Surgical History: □ None
Diet / Nutrition: List dietary restrictions/sensitivities □ Regular diet □	ergies: List all allergies and reactions No known allergies
Treatments / Medications: List treatments/medications to be continued at camp (**ALL MEDICATIONS MUST HAVE A PRESCRIPTION	
Licensed Physician/Healthcare Provider Authorization: I have reviewed the patient health history form and have discussed the camp that the patient is physically and emotionally fit to participate in an active camp	
Address: Cit	ty:

Address:		City:		
State:	Zip Code:	Phone:		
Name of Provider:	Signature:		Date:	