

Participant Health-Care Recommendations by Licensed Medical Personnel Form B

Participant Name: _____
Last First Middle Initial

Dates will attend camp/program: from _____ to _____
Month/Day/Year Month/Day/Year

Birth Date: _____ Sex: _____ Age on arrival at camp/program: _____
Month/Day/Year

Participants Home Address: _____
Street & Number City State Zip

MEDICAL EXAMINATION to be completed and signed by licensed medical personnel

<p>Physical Exam done today: <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," date of last physical: _____) <small style="margin-left: 350px;">Month/Day/Year</small></p> <p>Hgt _____ Wt _____ B.P. _____</p> <p>PcPO standards specify physical exam within last 24 months.</p>
<p>Allergies: <input type="checkbox"/> No Known Allergies <input type="checkbox"/> Known allergies (<i>list</i>) _____</p>
<p>Diet, Nutrition: <input type="checkbox"/> Eats a regular diet. <input type="checkbox"/> Special meal plans or diet restrictions (<i>describe below</i>) _____ _____ _____</p>
<p>The participant is under the care of a physician for the following conditions: (describe below) <input type="checkbox"/> None _____ _____ _____</p>
<p>Medication: <input type="checkbox"/> No daily Medications. <input type="checkbox"/> Will take the following medication(s) while at camp/program: (<i>name, dosage, frequency - describe below</i>)</p>
<p>Other treatments/therapies to be continued at camp/program: (describe below) <input type="checkbox"/> None needed</p>
<p>Do you feel the participant will require limitations or restrictions while in camp/program? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered "yes" to the question above, what do you recommend? (describe below - attach additional information if needed)</p>

I examined this individual on _____. In my opinion, the applicant is able to participate in an active camp/program.
Month/day/year

SIGNATURE OF LICENSED MEDICAL PERSONNEL _____ Date: _____
Month/Day/Year

Print Name _____ Title _____

Address _____ Phone: (_____) _____
Street & Number City State Zip