

PRINT OUT FOR HEALTHCARE PROVIDER

Camp Sweet Escape Physical Form

Physical exam MUST be performed by a licensed medical provider within the last 12 months of the start date of camp.

Campers Full Legal Name: _____

Preferred Name: _____ Age: _____ Male Female

Date of Birth: ____/____/____

Date of physical: _____

HgbA1c: _____% (if diabetic) BP: _____/_____ Weight: _____ Height: _____

Date of last HgbA1C if different from physical date: _____

Dietary Restrictions:

Medications to be administered at Camp with dose and frequency:

Allergies and Treatment: (i.e. does camper require Epi-Pen?)

Recommendations and Restrictions at Camp:

Please include any information regarding behavioral health that you feel is important to ensure the camper's safety and well-being while at camp:

Signature of Licensed Medical Personnel: _____

Printed Name: _____ Date: _____

Address: _____ Phone: _____

Camp Screening: (for camp use only at registration)

Date: _____ Time: _____ Screened by: _____

Open sores/Infection/Lice? _____

Lipodystrophy/Lipohypertrophy? _____

Other? _____

Identified health issues that could interfere with camper's ability to fully participate in camp activities? _____

MD Signature: _____