Camp Sweet Escape Physical Form 2024

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

PRINT OUT FOR HEALTHCARE PROVIDER

Campers Full Legal Name:_____

Preferred Name:_____**Age**:_____ **Male** **Female**

Date of Birth:_____/_____/_____

Date of physical: _____

HgbA1c: _____% **BP:** _____/_____**Weight:** _____**Height:**_____

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:_____

Medications Received at Camp:_____

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:_____