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

Physical Exam done today: ☐ Yes ☐ No (If "No," date of last physical: _____)
Month/Day/Year

Hgt_____ Wt_____ B.P._____

PcPO standards specify physical exam within last 24 months.

Allergies: ☐ No Known Allergies

☐ Known allergies ***(list)*** _____

Diet, Nutrition: ☐ Eats a regular diet.

☐ Special meal plans or diet restrictions ***(describe below)*** _____

_____

_____

The participant is under the care of a physician for the following conditions: (describe below) ☐ None

_____

_____

_____

Medication: ☐ No daily Medications.

☐ Will take the following medication(s) while at camp/program: ***(name, dosage, frequency – describe below)***

Other treatments/therapies to be continued at camp/program: (describe below) ☐ None needed

Do you feel the participant will require limitations or restrictions while in camp/program? ☐ Yes ☐ No

If you answered "yes" to the question above, what do you recommend? (describe below – attach additional information if needed)

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*