



2021 Physical Examination

TO BE COMPLETED BY A LICENSED PHYSICIAN OR NURSE PRACTITIONER		
Name (Last, First, Middle):		
Normal	Abnormal & Specify	
Heart		
Eyes		
Nose		
Ears		
Throat		
Lungs		
Extremities		
Height:	Weight:	Blood Pressure:
The applicant is under the care of a physician for the following condition(s):		
Current Treatment:		
Does the applicant have epilepsy? Yes _____ No _____	Diabetes? Yes _____ No _____	Sickle Cell Anemia or Traits? Yes _____ No _____
Recommendations and Restrictions While at Camp <small>(Camp is at an altitude up to 7700 feet; respiration problems may be exacerbated.)</small>		
Any treatment to be continued at camp?		
Any medication to be administered at camp? <small>(Specific dosages)</small>		
Any medically prescribed meal plan or dietary restrictions? <small>(Include PRN's)</small>		
Check only those activities that the applicant may NOT participate in: <input type="checkbox"/> Swimming <input type="checkbox"/> Extended Hiking <input type="checkbox"/> Strenuous Athletics		
Areas of Concern while at Resident Camp:		
Doctor's Name:	Phone:	
Address:		
Doctor's Signature:		Date of Examination: