Section 2---The following pages must be filled out by a Licensed Medical Personnel

I examined: _____on, _____(date).
BP: _____ Weight: _____ Height: _____
In my opinion, the above applicant: **_____is _____ is not** able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

Recommendations and restrictions at camp:

Treatment to be continued at camp:

Medications to be administered at camp including over-the-counter meds (name, dosage, frequency):

Known allergies:

Please indicate if the participant has/does:

_____had any recent injury/illness/infectious disease
_____has ever had a head injury
_____has ever been knocked unconscious
_____wears glasses/contacts/eyewear
_____ever had seizures
_____bringing an orthodontic appliance to camp
_____has problems with sleepwalking
_____has a chronic or recurring illness/condition

Explain any restrictions to activity:

Do any medications require special handling (i.e. refrigeration or protection from light?)
YES NO (circle)

If yes, what are the special handling requirements:

THIS FORM MUST BE SIGNED BELOW BY A LICENSED MEDICAL PERSON
Signature of Licensed Medical Personnel

_____
Printed name of Licensed Medical Personnel

_____

Address _____

Phone _____Date _____