CAMP PHYSICAL EXAMINATION

This examination must be performed within 12 months of camp.

TO THE EXAMINING PROVIDER (M.D., D.O., P.A.-C, N.P.) You are being asked to certify that this individual has no contraindication for participation in a rigorous outdoor overnight camping experience.

Child's Name: ____ Age: _____ Sex: ☐ Male ☐ Female

Height: __________ Weight: _________ Blood Pressure: _________________________ Pulse: ____________________

	Normal	Abnormal	Explain Any Abnormalities
Eyes			
Ears			
Nose			
Throat			
Lungs			
Neurological			
Heart			
Abdomen			
Skin			
Extremities			
Emotional Adjustment			

Other	Yes	No
Contacts		
Dentures		
Braces		

Medical Equipment (CPAP, O2, AFO):

Allergies

Current Epilepsy Treatment: ☐ Medication
☐ Vagus Nerve Stimulator ☐ Ketogenic Diet
☐ Other ______________________________________

Seizure Classification: Type 1: ___________________________________ Type 2: ____

Other chronic or recurring illnesses or physical limiting conditions: ____

Describe any behavior disturbance: ____

Special instructions/comments/limitations: ____

Does child have emergency medications prescribed for emergent seizures (clusters/prolonged seizures)? ☐ Yes ☐ No

LIST ALL MEDICATIONS CHILD IS CURRENTLY TAKING

Medication	Dose	Frequency

EXAMINER'S CERTIFICATION

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in an overnight outdoor camping experience. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

___________________________________	___________________________________	________________________________
Examining Physician (Print)	Signature	Date
___________________________________	___________________________________	________________________________
Address	City, State, Zip	Phone Number