2017 PROMISE CAMP CAMPER PHYSICAL EXAMINATION FORM

(physician's own form acceptable - this is a guideline)

This information must be completed by a licensed physician or nurse practitioner based on a physical examination which must have been performed **WITHIN A YEAR OF THE CAMPER'S WEEK AT PROMISE CAMP 2017.**

Patient Name: _____ ☐M ☐F Date of Birth: _____

Date of Physical Examination: _____ Today's Date _____

Height: _____ Weight: _____ Blood Pressure:_____

Is patient currently under care of a physician and/or under psychiatric care? ☐Y ☐N

If yes, please describe: _____
_____
_____

The participant is currently receiving the following medical treatment: _____
_____
_____

Treatment(s) to be continued while at Promise Camp: _____
_____
_____

Medication(s) to be administered at Promise Camp (include name, dosage & frequency):
_____
_____
_____
_____

Dietary Restrictions while at Promise Camp: _____
_____
_____

Known Allergies (to medications, food, latex or other substances) and type of reaction: _____
_____
_____

Treatment for above-listed allergies: _____
_____
_____

Physical limitations or restrictions while at camp: _____
_____
_____

Date of camper's last tetanus shot: _____

Signature (or electronic signature) of Physician/CRNP: _____

Print Provider Name: _____ Phone: _____