

# MEDICAL EXAMINATION by LICENSED MEDICAL PERSONNEL

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  Male  Female  
Camp Name: \_\_\_\_\_ Session: \_\_\_\_\_

Please have your child's primary healthcare provider complete this form. Once complete, scan and upload the document to your CampDoc.com account or return it to your camp.  
\*Keep the original copy for your own records\*

**Girl Scout standards require a physical exam within last 24 months for campers attending Camp Evelyn for three or more nights**

Physical exam performed today?  Yes  No Date: \_\_\_\_\_  
If "No", date of last physical exam? \_\_\_\_\_

Height: \_\_\_\_\_  
Weight: \_\_\_\_\_  
Blood Pressure: \_\_\_\_\_

**Conditions** List conditions for which the above participant is receiving treatment  None

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Restrictions** List activity restrictions  No restrictions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Medical / Surgical History**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Diet / Nutrition** List dietary restrictions  Eats a regular diet

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies** List all allergies and reactions  No known allergies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Treatments / Medications** List treatments/medications to be continued at camp (include name, dose, frequency)  None

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physician Authorization:**  
I have reviewed the patient health history form and have discussed the camp program with the patient's parents/guardians. It is my opinion that the patient is physically and emotionally fit to participate in an active camp program (except as noted above).

Address: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

City: \_\_\_\_\_  
Phone: \_\_\_\_\_

\_\_\_\_\_  
Name of Licensed Provider

\_\_\_\_\_  
Signature Date