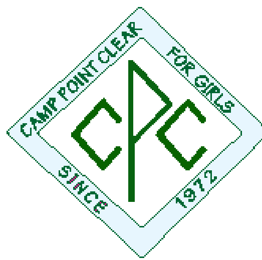

Camper Name____

CAMP POINT CLEAR PHYSICIAN'S FORM P. 1

This person is in satisfactory condition and may engage in all activities except those noted below.

Physician's Name____

Signature____

Address____

City_________________________ **State**______ **Zip**____________

Camper's age at camp___________________**DOB**_____________

Parent's or Guardian's Name____

Home Address_______________________________**City**________________________

State__________ **Zip**____________

Mother's Cell___________________ **Father's Cell**______________________

Emergency Contact_______________________________**Phone**_______________________

IMMUNIZATIONS: Attach Camper's Immunization Record (Required)

PHYSICIAN'S FORM P.2 Camper Name:_________________________

(Check) ALLERGIES ______ Hay Fever _______ Asthma____ Insect Sting _____Poison Ivy, Oak, etc. _________OTHER________________________

List Food Allergies____

___ Ear infection ___ Heart Disease ____ Convulsions ____ Diabetes

___Behavior ___Headaches

Date of last examination:__________________Height____________Weight_________

Appearance-Nutrition_____________________________

Code: Satisfactory (S) NS (Not Satisfactory)

Ears______ Throat______ Nose_______ Heart _____ Teeth ______

Musculoskeletal_____ Abdomen ______ Lungs _____ Skin______

Operation or other serious injuries (Date)

____

Hospitalizations____

Comments where applicable:

Fainting_____________________ Sleep Disturbances_____________________

Menstruation_____________ Constipation______________________________

Bed Wetting____

Specific Activities to be restricted____

Notes:____