Camp Strawderman
Health Certificate
To be Filled Out by Physician

MEDICAL EXAMINATION: This must be completed by a licensed health care professional that has seen and examined this patient in the last 12 months.

Camper Name: _____

Date of physical exam: _____

****PLEASE ATTACH A COPY OF CAMPER'S IMUNIZATION RECORD****

Weight: _____ Height: _____ Blood Pressure: _____

In your opinion, is the above applicant able to participate in an active camp program including horseback riding, swimming, and hiking? _____

Please list any medical or psychiatric conditions for which this child is receiving care by a health care professional: _____
_____
_____

Treatments or Medications to be continued while at camp: _____
_____
_____

Known allergies. Please describe reactions: _____
_____
_____

Medically prescribed meal plan or dietary restrictions: _____
_____
_____

Description of any limitation or restriction on camp activities: _____
_____
_____

PHYSICIAN SIGNATURE: _____ TITLE: _____

PRINTED NAME: _____ DATE: _____

ADDRESS: _____

PHONE NUMBER: _____