SHOT HISTORY

1. Please attach a record of your shots.
2. Have you had a complete physical exam within the last two years? Please circle your response: YES NO
3. Please write your doctor's name, address and telephone number:

Doctor's Name _____ Address _____ Telephone # _____

HEALTH EXAMINATION BY LICENSED PHYSICIAN

(ONLY IF YOU HAVE NOT HAD A PHYSICAL IN THE LAST TWO YEARS)

1. I have examined the above camp applicant. Date Examined: _____
2. In my opinion, the above's condition (___does ___does not) preclude his/her participation in an active camp program.
3. The camp applicant is under the care if a physician for the following conditions: _____
4. Current treatment (include current medications):_____
5. Explanation of any reported loss of consciousness, convulsions, or concussions: _____
6. a.) Does the applicant have epilepsy? Yes No b.) Does the applicant have diabetes? Yes No
7. Recommendations and restrictions while at Camp. _____
8. Any treatment to be administered at camp (specific dosages):_____
9. Any medically prescribed meal plan or dietary restricitions: _____
10. Any allergies (food, drugs, plants, insects, etc.):_____
11. Additional health information: _____

Licensed Physician Signature: _____

Address: _____ **Phone** (_____) _____

Date form completed _____ *By_____
*Initial if completed by a nurse or physician's assistant.