

Camp Paha Medical Examination
TO BE FILLED OUT BY YOUR HEALTH CARE PROVIDER

Camper's Name _____ **DOB:** _____

Purpose: To determine camper's physical fitness to engage in camp activities. The requested information may be taken from a medical examination within 12 months of the start of Camp Paha (UNLESS OTHERWISE REQUESTED).

Camper/Participant Health Assessment

Codes: V = Satisfactory x= Not Satisfactory (explain) o= Not Examined				
Height:	Weight:	Eyes:	Nose:	Throat:
Lungs:	Abdomen:	Hernia:	Spine:	Heart:
BP:	HCT/HGB:	Urinalysis:	Skin:	Extremities:
Allergies: (be specific to degree and reaction)				
This camper is under the care of a physician for the following conditions				
General Health Appraisal:				

In my opinion, the above Camper:

- ☐ IS able to participate with no restrictions/considerations
- ☐ IS NOT able to participate in an active camp program
- ☐ IS ONLY able to participate in an active camp program with the following restrictions:

It is my opinion that this person is physically able to engage in Camp activities except as noted above.

Signature: _____, M.D. Telephone _____

Signature printed: _____ Date: _____

Please upload to your Camper's Profile in the registration system. If you are unable to scan/upload, please fax (with cover sheet including camper's name) to 303-987-4803. Be sure to also complete applicable Permission To Medicate Forms! (signed by a doctor)