Camper Medical History & Physical Exam Form

(To be completed by camper's primary health care provider)

To attend camp, all campers must submit:

1. This completed medical history physical exam form, including provider signature
2. A copy of the camper's immunization record
3. A copy of the camper's health insurance card

Fax 3 documents to Medical Director, Dr. Jennifer Hosterman at **Fax: 570-271-6852**

Camp ENERGY Medical Director will have final approval on camp attendance
Contact: campenergy@gmail.com or 570-412-1458

Camper's Name: _____ Sex: M or F DOB: _____

Date of Measurements: _____ BP: _____ Weight (lb) _____ Height: _____

Allergies (list specific food or allergen and reaction):

_____

_____

Record of Immunizations (list date and **provide a copy of immunizations**):

DTP	_____	MMR	_____	Polio	_____	HIB	_____
TD	_____	Hepatitis	_____	Varicella	_____	Menactra	_____

List any chronic or current physical, behavioral or mental health problems (use a separate sheet if necessary):

_____

_____

_____

_____

_____

_____

(More questions and Doctor's signature on back)

Fax to: Jennifer Hosterman, DO at (570) 271-6852

List any dietary restrictions (vegetarian, vegan, no pork, lactose intolerance). Please be specific:

_____

_____

Does the patient have any medical, emotional, or behavioral problems that could preclude them from participating in camp? If yes, please explain including current treatment (if any) and any precautions or restrictions:

_____

_____

_____

Current Medications

Drug Name	Dose	How Taken	How Often/When
Example: Albuterol	2 puffs	By inhaler	Twice daily at breakfast and bedtime

Has the camper received the COVID-19 vaccination? ____ If so, the date of the last dose: ____
If not, do they have a medical condition that exempts them from receiving the vaccination?____

☐ Please check the box if you would like an update after camp so that you may help your patient continue their healthy lifestyle goals. We believe a large support system is a great asset!

Medical Provider (Campers must have been examined within 1 year)**:**
The patient was examined on _____.
Please check one box below:
☐ I recommend the patient to camp without restriction.
☐ I recommend them to camp with the following restrictions_____.
☐ I cannot recommend for camp for medical reasons.

Provider signature: _____ Date: _____

Provider name (please print): _____ Office phone #: _____

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