

# Universal Physical Form

Camps and activities require each camper to have a completed copy of this form or an equivalent form generated by a medical facility prior to attending.

This form is to be completed by a medical professional, preferably the camper's primary care physician.



Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Program Session Date: \_\_\_\_\_

Parent/Gaurdian Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**Physical Exam Completed Today:**      YES      NO      If "NO" date of last physical: \_\_\_\_\_

Weight: \_\_\_\_\_      Height: \_\_\_\_\_      Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_

**Allergies:**      \_\_\_ NO known allergies

\_\_\_ To Foods (LIST):

\_\_\_ To Medications (LIST):

\_\_\_ To the Environment (LIST):

\_\_\_ Other (LIST):

**Describe previous reactions:**

**Diet/Nutrition:**      \_\_\_ Eats regular diet

\_\_\_ Has medically prescribed meal plan or dietary restrictions (describe below):

**Child is undergoing treatment for following conditions (describe below):**      \_\_\_ None

**Medications:**      \_\_\_ None

\_\_\_ Will take the following prescribed medications while at the program (name, dose, frequency):

**Will the child require limitations or restrictions to program activities?**      \_\_\_ NO      \_\_\_ YES (Describe YES below):

**I have reviewed this child's medical history and have discussed the program with the child's parent/gaurdian. It is in my opinion that the child is physically and emotionally fit to participate in an active camp or program (Except as noted above.)**

Name of Licensed Provider (print): \_\_\_\_\_ Signature: \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Date: \_\_\_\_\_