

Staff Physical Information Form

email to (robinhome@aol.com) at least 2 weeks prior to your camp start date.

CVL PHYSICAL FORM

We will accept your Doctor's Physical Form also, as long as it was completed **within 12 months** of the camp session.

Please keep a copy for your records.

Staff Full Name: _____

Medical Personnel: Please Attach any additional information if needed.

TO BE COMPLETED BY A LICENSED PHYSICIAN:

I have examined: Name _____ Date of Exam: _____

Last First Middle

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Birth Date ___/___/___ Age _____

PLEASE CHECK YES OR NO. EXPLAIN ALL 'YES' ANSWERS IN FULL

Is the applicant under the care of a physician for any condition(s)? Yes No _____

Is the applicant undergoing treatment at this time for any conditions: Yes No _____

Medications: No medications Will take the following prescribed medications while at camp: (include name, dose, frequency)

Diet, Nutrition: Eats a regular diet Has a medically prescribed meal plan or dietary restrictions: (describe below)

Has there been any reported loss of consciousness, convulsion, or concussion? Yes No _____

Does applicant have epilepsy? Yes No _____

Does applicant have diabetes? Yes No _____

Any treatment to be continued at camp? Yes No _____

Any allergies (food, drugs, plants, insects, etc.)? Yes No _____

Activities to be encouraged or limited? Yes No _____

Additional Health Information: Yes No _____

In my opinion, the above candidate: Is Is Not able to participate in an active camp program which may include swimming, canoeing, climbing, and other strenuous activities.

Licensed Physician's Signature _____ Phone (_____) _____

Print Physician's Name _____ Fax (_____) _____

Date of Completion _____ By: _____

*Initial if completed by nurse or physician's assistant

Signature: _____ **Date:** _____