Camp Challenge Physician’s Report

**Physical Exams must be dated after January 1st of the camp year.**

**CAMPER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Report**

(This part must be completed by a physician & turned in with the application)

**PRIMARY DIAGNOSIS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OTHER DIAGNOSIS STATUS OF EACH DIAGNOSIS**

 2.

 3.

**Physical Examination**

 Height Weight Heart Rate Blood Pressure Respiration Rate

(PLEASE CHECK IF NORMAL OR ABNORMAL)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Normal | Abnormal  | Explain if necessary |
| HEENT |  |  |  |
| NECK |  |  |  |
| LUNGS |  |  |  |
| HEART |  |  |  |
| ABDOMEN |  |  |  |
| GENITALS |  |  |  |
| SPINE |  |  |  |
| EXTREMITIES |  |  |  |
| NEURO |  |  |  |
| SKIN |  |  |  |

List chronic or recurring conditions:

Medications: Please list or attach

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Limitations of Activities:

Other Recommendations

**Licensed Physician’s Signature**

I have examined the above applicant, in my opinion he/she can participate in an active camp program.

Physician’s Signature Date of Exam

Printed Name Phone Fax

 Address

 Street/box City State Zip

**When completed, PLEASE UPLOAD INTO YOUR APPLICATION PORTAL.**

**OR you may email to** **campchallengemail@gmail.com****,**

**Or fax to 1-866-295-3803**