



CAMP NAZARETH

Retreat and Conference Center

339 Pew Road, Mercer, PA 16137
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MEDICAL EXAMINATION FORM

To be filled out and signed by a **Licensed Medical Professional**

To attend Camp a medical examination is required within 12 months of the camping session. If an exam was already done in that time period, your physician may be willing to fill out the form below without an additional exam. **This form must be completed and signed by an approved, licensed medical professional (licensed physician or physician's assistant) in order to attend Camp.** Please be sure this entire form is complete. This form follows the most recent standards of the ACA and is a necessary part of the application process. Thank you for your cooperation.

I examined _____ this individual on the date of _____

Name of Potential Camper/Applicant

Date of Examination

Blood Pressure: _____ Height: _____ Weight: _____

In my opinion, the above applicant is or is not able to participate in this summer's active camp program.

The applicant is under the care of a physician for the following conditions: _____

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

PLEASE GIVE ALL DATES OF IMMUNIZATION FOR:

- DTP _____
- TD (Tetanus/Diphtheria) _____
- Tetanus _____
- Polio _____
- MMR _____
- or Measles _____
- or Mumps _____
- or Rubella _____
- Haemophilus Influenza B _____
- Hepatitis B _____
- Varicella _____

TB Mantoux Test

Date of last test _____

Result: Positive Negative

Recommendations and Restrictions at Camp

Treatment to be continued at camp: _____

Medications to be administered at camp (name, dosage, frequency): _____

Any medically prescribed meal plan or dietary restrictions: _____

Known Allergies: _____

Description of any limitation or restriction on camp activities: _____

Additional information for health care staff at the camp: _____

Signature of Licensed Medical Professional: _____
Printed Name: _____ Title: _____
Address: _____
Phone: _____ Date: _____

The section below is for Camp Personnel uses only, please disregard:

Screening Record at Check-In
Date Screened: _____ Time: _____ am/pm
Medications received (Prescription and non-prescription): _____

Updates/additions to health history? Yes No If yes, _____

Current health needs identified? _____

Observational notes: _____

Screened by: _____