MEDICAL SCREEN FORM

*This form is to be completed by a Physician **OR** provide a copy of a physical exam form signed by a physician indicating clearance to participate.*

THIS FORM MUST BE DATED WITHIN **12 MONTHS** OF THE DATE OF THE CAMP.

PARTICIPANT NAME:	
BIRTH DATE:	CAMP:

Head	YES	NO	
ENT	YES	NO	
Neck / Back	YES	NO	
Heart	YES	NO	
Abdomen	YES	NO	
Genitalia	YES	NO	
Extremities	YES	NO	
COMMENTS			

Asthma	YES	NO
Currently taking **ANY** prescription medication	YES	NO
Please list:		
Date of last Tetanus Shot/Booster:		
Known Allergies:		
Other Special Considerations (i.e. dietary needs, diabetes, etc.)		

SPORTS PARTICIPATION APPROVED: YES NO

LIMITATIONS: YES NO

Please list: _____

_____

Emergency Contact: _____

Phone Number: ( ) _____

Physician's Signature: _____

Physician's Phone Number: ( ) _____

Date: _____