Provider's Report

This information must be completed by the camper's medical provider and returned by May 18, 2022.
Failure to submit the completed form by this date may result in losing your spot at camp.
Date of provider visit (today's date): _____

Camper First Name: _____ Camper Last Name: _____

Birth Date: _____ Height: _____ Weight: _____ Blood Pressure: _____

Most recent hemoglobin AIC: _____ Date Recorded: _____ (Must be after 1/1/22)

Allergies (food, medication, other):

Current medications/dose:

Check the following if normal:

□ Fundoscopic Exam □ Thyroid □ Lungs □ Heart

□ Fingertips □ Injection Sites □ Behavior □ Abdomen

If abnormal, comment: _____

Medical diagnosis/psychological, emotional or behavioral diagnosis/concerns:

□ I have examined the above camper and identified current medical problems.

This camper may participate in all camp activities except:

_____

Provider's name: _____ Office phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Provider's signature_____ Date_____