

# Camp Gilbert Provider's Report

This information must be completed by the camper's medical provider and returned by May 19, 2023.

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 A1C: \_\_\_\_\_ Date Recorded: \_\_\_\_\_ (Must be after 1/1/23)

Allergies (food, medication, other):

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Current medications/dose:

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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:

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

This camper may participate in all camp activities except:

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Provider's name: \_\_\_\_\_ Office phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Provider's signature \_\_\_\_\_ Date \_\_\_\_\_