-- KEEP A COPY OF THE COMPLETED FORM FOR YOUR RECORDS --

Camper Name: _____ Age: _____

THIS PORTION MUST BE COMPLETED, SIGNED/STAMPED AND DATED BY A MEDICAL PROFESSIONAL. "Medical Professionals" recognized by Camp Wastahi to perform this exam include: Physicians (MD, DO), Nurse Practitioners, and Physician's Assistants.

To the Provider: Please fill out this form with most current physical exam findings. The participant must have had a physical within 24 months of July 1, 2019. *If there have been changes in health since previous exam, a new physical is required*. Provider may use own form, if available. Please attach additional pages as needed.

PHYSICAL EXAMINATION:

Camper Name: _____ Age at camp: _____
Date of Physical Exam: _____/_____/_____Height_____ Weight_____
Blood Pressure: _____ Pulse:_____

ALLERGIES: ***check and detail all that apply***

☐ **ANAPHYLACTIC** ☐ To the environment (Insect stings, hay fever, etc. – list)
☐ To foods (list) ☐ Other allergies (list) ☐ **No known allergies**

Detail reactions and antidote:

_____
_____
_____
_____
_____

DIET AND NUTRITION:

☐ Eats a regular diet ☐ Has a medically prescribed meal plan or dietary restrictions (describe below):

_____
_____
_____
_____
_____

MEDICATION/TREATMENTS: ***check and detail all that apply***

☐ No daily medications
☐ Will take the following medication(s) while at camp (name, dose, frequency – describe below)
☐ Other treatments/therapies to be continued at camp: (describe below)

_____
_____
_____
_____
_____

(For Camp Use) Cabin Group _____

Ph: 831-204-8445 Mail: 4484 Desin Drive San Jose, CA 95118 Email: water.stars.hills@gmail.com **EIN: 26-4338693**

ADDITIONAL COMMENTS/CONCERNS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I certify I have reviewed the health history, examined this person, and approve this individual's participation in:

Hiking: ☐ Yes ☐ No ☐ ***With Restrictions** **Competitive Activities**: ☐ Yes ☐ No ☐ ***With Restrictions**

Sports: ☐ Yes ☐ No ☐ ***With Restrictions** **Sleeping Outdoors**: ☐ Yes ☐ No ☐ ***With Restrictions**

Swimming/Water Activities: ☐ Yes ☐ No ☐ ***With Restrictions**

***To Health Care Provider:** **Restricted approval includes, but is not limited to:*

- ☐ Uncontrolled heart disease, asthma, or hypertension.
- ☐ Uncontrolled psychiatric disorders.
- ☐ Poorly controlled diabetes.
- ☐ Newly diagnosed seizure events (within 6 months)
- ☐ Other: _____ (please detail below)

***Specific Restrictions and Instructions:** (if none, write N/A)

_____
_____
_____
_____
_____
_____

Provider Name (print) _____ Date _____

Provider Signature _____ Office phone (_____) _____

Address _____

Camper Name: _____ Age: _____

(For Camp Use) Cabin Group _____