

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

Camper Name: ___

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:

Communa Name at any management of the community of the co	
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	Age:
Detail reactions and antidote:	
DIET AND NUTRITION:	·
☐ Eats a regular diet ☐ Has a medically prescribed meal plan or dietary restrictions (describe below):	(For Camp Use) Cabin Group
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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)	
	
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Wastahi 2019 Physician Form

Certify have reviewed the health history, examined this person, and approve this individual's participation in:	ADDITIONAL COMMENTS/CONCERNS:	
certify I have reviewed the health history, examined this person, and approve this individual's participation in: diking: Yes No *With Restrictions No *With Restrictions diking: Yes No *With Restrictions Sleeping Outdoors: Yes No *With Restrictions ports: Yes No *With Restrictions Uncontrolled heart disease, asthma, or hypertension. Uncontrolled psychiatric disorders. Peorly 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 () Provider Signature Office phone ()		Camp
certify I have reviewed the health history, examined this person, and approve this individual's participation in: diking: Yes No *With Restrictions Yes Yes No *With Restrictions		er Nai
Stiking: Yes No *With Restrictions Sleeping Outdoors: Yes No *With Restrictions Sports: Yes No *With Restrictions Sleeping Outdoors: Yes No *With Restrictions Swimming/Water Activities: Yes No *With Restrictions With Restrictions No With Restrictions With Re		ne:_
Competitive Activities: Yes No *With Restrictions Sleeping Outdoors: Yes No *With Restrictions Sleeping Outdoors: Yes No *With Restrictions Wimming/Water Activities: Yes No *With Restrictions With Restrictions		_
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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) Provider Restrictions and Instructions: (if none, write N/A) (For Camp Use) Cabin Group Cabin Grou		's
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) Office phone (Hiking: □ Yes □ No □ *With Restrictions Competitive Activities: □ Yes □ No □ *With Restriction	ns
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:	Sports: ☐ Yes ☐ No ☐ *With Restrictions Sleeping Outdoors: ☐ Yes ☐ No ☐ *With Restriction	ns
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 ()	Swimming/Water Activities: Yes No *With Restrictions	
Provider Name (print) Date Office phone ()	 ☐ Uncontrolled heart disease, asthma, or hypertension. ☐ Uncontrolled psychiatric disorders. ☐ Poorly controlled diabetes. ☐ Newly diagnosed seizure events (within 6 months) 	Age:
Provider Name (print)	*Specific Restrictions and Instructions: (if none, write N/A)	
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