

**Sherman Lake YMCA Outdoor Center**  
**CAMPER HEALTH CARE RECOMMENDATIONS**  
*(To be completed by a licensed physician)*

Parent /Guardian Please Complete this section: Dates will attend camp: from \_\_\_\_\_ to \_\_\_\_\_

Camper Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age at camp \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
 Home Address: \_\_\_\_\_

Custodial Parent: Name \_\_\_\_\_ Phone \_\_\_\_\_

*Remainder of form to be completed by medical personnel.*

**Medical Personnel: Please complete all remaining sections of this form. Attach additional information as needed:**

Physical Exam Done today \_\_\_ Yes \_\_\_ No, If No, date of last physical: \_\_\_\_\_

ACA accreditation standards specify physical exam within last 24 months.

Height \_\_\_\_\_ Weight \_\_\_\_\_ B.P. \_\_\_\_\_ Hct.or Hgb. Test \_\_\_\_\_

**Code: S- satisfactory NS – not satisfactory (explain) O – not examined**

Eyes _____	Extremities _____	Genitalia _____	ALLERGIES:
Glasses _____	Including:	Skin _____	Foods: _____
Ears _____	Feet _____	Lungs _____	Meds: _____
Nose _____	Shoulder _____	Abdomen _____	Environment: _____
Throat _____	Knees _____	Hernia _____	_____
Heart _____	Ankles _____	Spine _____	

GENERAL APPRAISAL: \_\_\_\_\_

For Females: Has this person menstruated? \_\_\_\_\_ If so, is her menstrual history normal? \_\_\_\_\_

Any Special Considerations: \_\_\_\_\_

***Recommendations and/or restrictions while in camp:***

Diet: Eats a regular diet? \_\_\_\_\_ Has medically prescribed meal plan or dietary restrictions: \_\_\_\_\_

Swimming , Diving: \_\_\_\_\_ Strenuous Activity: \_\_\_\_\_

Will the camper require limitations or restrictions to activities while at camp? \_\_\_ No \_\_\_ Yes Describe: \_\_\_\_\_

Please list all Physician Orders for medication or treatment. The Camp Health Officers will follow M.D. orders.

**MEDICATION**

Medication	Dosage	Freq. (#days)	Times	Indicate reason

TREATMENTS: \_\_\_\_\_

***PHYSICIAN'S SIGNATURE REQUIRED***

On the basis of your knowledge of the applicant, the applicant's medical history, the present physical examination of this applicant, and your knowledge of the activities in which they will be asked to participate, do you feel this individual is able to participate in the Sherman Lake YMCA Outdoor Center program?   πYES       πNO

Name of Physician (Please Print) \_\_\_\_\_

Office Address \_\_\_\_\_

Telephone (    ) \_\_\_\_\_ Date \_\_\_\_\_ Physician's Signature \_\_\_\_\_

. It is not necessary to have a new physical specifically for camp. A licensed medical practitioner is to complete this form prior to participation and note any physical impairment that may interfere with camp participation and that all campers are free from communicable and contagious disease. ALL INFORMATION IS KEPT CONFIDENTIAL. After thoroughly completed, please send it to or drop it off at: **The Sherman Lake YMCA Outdoor Center, 6225 N. 39th Street, Augusta, MI 49012, (269) 731-3000.**