

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.**