Camp Pelican Physician's Report

Physical Exams must be dated after January 1st of the camp year.

CAMPER NAME: _____

Physician's Report

(This part must be completed by a physician & turned in with the application)

PRIMARY DIAGNOSIS: _____

	OTHER DIAGNOSIS	**STATUS OF EACH DIAGNOSIS**
2.	_____	_____
3.	_____	_____

Physical Examination

Height _____ Weight _____ Heart Rate _____ Blood Pressure _____ Respiration Rate _____

(PLEASE CHECK IF NORMAL OR ABNORMAL)

	Normal	Abnormal	Explain if necessary
HEENT			
NECK			
LUNGS			
HEART			
ABDOMEN			
GENITALS			
SPINE			
EXTREMITIES			
NEURO			
SKIN			

List chronic or recurring conditions: _____

Medications: Please list or attach

_____

Limitations of Activities: _____

Other Recommendations _____

Licensed Physician's Signature

I have examined the above applicant, in my opinion he/she can participate in an active camp program.

Physician's Signature_____ Date of Exam _____

Printed Name_____ Phone_____ Fax_____

Address_____
Street/box City State Zip

When completed return to:

Please upload your form to the online application site-if not, please fax or email it to

Camp Pelican
Fax: 1-866-295-3803
camppelican@gmail.com