



Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PHYSICAL EXAMINATION:** Describe if Abnormal

Ht (cm)	BP	Pulse
Wt (kg)	Temp	

	Normal	Abnormal	
General appr			<b>PHYSICAL LIMITATIONS AND RESTRICTIONS:</b>  PLEASE BE AS SPECIFIC AS POSSIBLE  Walking:  Jumping:  Climbing:  Swimming:  Any other physical restrictions or limitations:
Skin			
Eyes			
Ears/Nose			
Mouth/Teeth			
Thyroid			
Lymph Nodes			
Heart			
Lungs			
Abd			
Liver			
Spleen			
Musc/Skel			
Neuro			
GU:			
Other:			

**DOCTOR'S STATEMENT**

I have examined \_\_\_\_\_ who is physically able to engage in camp activities, except for physical limitations and restrictions listed on opposite page.

\_\_\_\_\_  
Physician or PNP's Signature

\_\_\_\_\_  
Typed or Printed Name

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone: (    ) \_\_\_\_\_