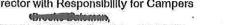


WILL FLOWS



Camp Director with Responsibility for Campers



1530 B Santa Rita Rd, Templeton CA 93465 THIS PART OF THE FORM IS TO BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN OR PERSON LICENSED TO PROVIDE MEDICAL INFORMATION AND ASSESSMENT.

## MEDICAL EVALUATION

TO PHYSICIAN: Review health history. If incomplete, please ask that this essential information be provided for your use. If health history of individual so indicates, a full examination should be performed,

PART A - Use this part ONLY if applicant has had an exam within the past 2 (two) years. If not, skip to Part B, PHYSICIAN'S HEALTH MEMORANDUM omplete physical examination is not done) \_\_\_\_ last had a medical examination on (Date) Name: . any activity was found except as noted below. and no c Individual should be restricted from: Individual is susceptible (or allergic) to: Other instructions: PART B - For use If applicant has NOT had a physical examination within the past 2 (two) years. Physical Examination 99/5 DWIIIh Glasses R20/ Left 20/ Vision 20/ Left 20/ 1. Eyes 7. Thyrold 12. Abdomen O 17. Skin (acne and scars) 0 0 2. Ears 13. Hemia 18. Reflexes O 8. Lymph nodes 0 O 3. Hearing 9. Chest(gynecomastia) 14. Genitalia (maturity) 19. Pilonidal sinus O 0 O 10. Heart 15. Extremitles (joints) 16. Skeletal (scoliosis) 4. Nose 0 20. Speech 0 21. Emotional adjustment 6. Throat 0 11. Lungs 6. Teeth Required Tests: Sugar? Albumin? If Indicated: Blood Count Chest Plate Tine Test Should be restricted from: Individual is susceptible to (or allergic) to: Physician's Assessment This person appears to be fit to participate in: Camping and Hiking Water Sports Competitive sports This person may request fransportation assistance from Angel Flight. Please confirm that this patient is medically stable and may fly in a small non-pressurized alreraft. YES L Please indicate the applicants: + Weinhf Helght Signature: (a 04) Address: State: City: Fax:

> ...... Llons Camp Camp Director with Responsibility for Campers

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## SAMPLE MED RELEASE COMBINED W/ PHYSICAL FORM Champ Camp 2015



## \* TO BE FILLED OUT BY A LICENSED PHYSICIAN OR NURSE PRACTICIONER\*

This examination is for determining fitness and general health to engage in a variety of basic activities while at CHAMP CAMP, a summer camp for burn-injured children.

PHYSI	CAL EX	AMINIATIO	INC	FORM	
Child's Name:		Age;_	E	Date of Birth	II.
Parents/Legal Guardian(s):					
Child's Weight:Lbs.	Height:	Blood Pressure	e:		
REQUIRED: Is this child med  Does this child have any current If yes, explain:	ically stable at → → □ conditions the	nd able to fly in a non-payer  YES □ NO ← ←  nt you are treating unde	ressuriz	ed small aire	
Is this child under any type of m therefore administer at camp? Y If yes, explain:	edications, an	d/or other treatments th	nat we s	hould know	about and
Has this child had any past medibroken bones, fainting, ear or eye If yes, explain:	e conditions, e	tc.) YES NO		PAGE NO. 10 ACCUSATE OF THE PAGE NO.	
Does this child have any allergie If yes, explain: ,	s and/or dieta	ry restrictions we need	to know	about? YE	S NO
Are there any activities to be enc If yes, explain:	ouraged or to	be restricted? YES	NO	· In	
Physician's Signature		Date		)Physici:	 an Number
,					
Address:		(•0			
Office Stamp Here: (Optional)	<b>3</b> .				*: