

Health Examination Form—to be completed/signed by physician



Mail or fax completed & signed form **NO LATER THAN TWO WEEKS PRIOR TO CAMP DATE** to:

**Rawhide Ranch
PO Box 216
Bonsall, CA 92003
Fax: 760-758-0440**

Camper Name _____ Birth Date _____
Last First

Gender: () Male () Female

Mailing Address _____
PO Box/Street City, State, Zip

Health Recommendations and Restrictions for Camp

I have examined the above camp participant:

(Note to physician/parent: date of last exam must fall within 24 months of camper's camp date to be valid.)

_____ **Date of last exam**

_____ **BP**

_____ **Weight**

_____ **Height**

Treatment to be continued at camp _____

Medications to be administered at camp (name, dosage, frequency) _____

Medically-prescribed dietary restrictions _____

Known allergies _____

Medical limitation/restriction on camp activities _____

In my opinion, the above participant () is / () is not able to participate in an active/physically demanding camp program.

Licensed Physician's Name: _____ **Date Signed by Physician** _____

Physician's Signature _____ Phone () _____

Physician's Address _____