

**MN ELK'S YOUTH CAMP  
HEALTH EXAMINATION FORM**

**To be completed by the parent:**

Name: \_\_\_\_\_ Sex: F M Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Phone: \_\_\_\_\_

In emergency notify \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Dentist/Orthodontist \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you carry family medical insurance? \_\_\_\_\_ If so, Name of Insurance Company \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Please list any meds sent with child \_\_\_\_\_ The camp nurse/aid will be administering these meds.

**PARENT'S AUTHORIZATION: This information is correct and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician. I hereby give permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.**

**Signature** \_\_\_\_\_ **Name Printed** \_\_\_\_\_

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**To be completed by a Licensed Medical Personnel:**

This exam should be performed within 3 months of arrival at camp. Date of exam \_\_\_\_\_

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

The applicant is under the care of a physician for the following conditions \_\_\_\_\_

Current treatment at the time of this report includes \_\_\_\_\_

**Recommendations and Restrictions at Camp**

Treatment to continue at camp \_\_\_\_\_

Medication to be administered at camp (name, dosage, frequency) \_\_\_\_\_

Known Allergies (Food, medication, or other) \_\_\_\_\_

Description of any limitation or restriction on camp activities \_\_\_\_\_

**Dietary Restrictions**

Please list any dietary restrictions that apply to this individual \_\_\_\_\_

**Please attach immunization record**

I have examined the person herein described and have reviewed his health history. It is my opinion that he is physically able to engage in camp activities, except as noted above.

**Signature of Licensed Medical Personnel** \_\_\_\_\_