100 bbyo

Participant's Full Name: ______________________________

Date of Birth (mm/dd/year): ______________________________

Home Address: ______________________________

Phone Number: ______________________________

Male ☐ Female ☐

PHYSICIAN EXAMINATION FORM

This examination must be performed by the teen's treating physician within 12 months of the program start date. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activity.

Height	Weight	Pulse	Blood Pressure

Please rate the following:
V – Satisfactory
X – Not satisfactory
O – Not examined

Eyes	Ears	Nose	Throat	Lungs	Heart	Abdomen
☐	☐	☐	☐	☐	☐	☐

General Appraisal
Please address any concerns from above.

Medications
Please list any medications the applicant is currently taking.

Allergies
Please list any allergies the applicant may have.

Does this teen have any of the following (Y/N):

- Anaphylactic reaction**: ______________________________
- Seizure Disorder: ______________________________
- Asthma: ______________________________

If yes, emergency protocol must be included.
***Please include specific information on what the teen has an anaphylactic allergy to.*

Current Medical Problems and Treatments Use a second sheet if needed.	
Recommendations List restrictions on the applicant at camp.	

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

I have examined the applicant today ☐ Yes ☐ No If no, date of examination: ____________

Name of Doctor: ____________________________ Signature: ____________________________

Contact Information: ____

Date: ____________________

Doctor Office's Stamp: ____