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# HEALTH EXAM

*This form is to be completed by a licensed healthcare provider - M.D., P.A., or N.P.*

GROUP:

**A completed Health Exam is required in order to participate in any Camp Hanover program.**

*Camp Hanover is accredited by the American Camp Association for the safe operation and high quality of our programs. So that we may meet the standards for accreditation, participants are required to provide a record of a health exam by a licensed healthcare provider which attests to the participant's ability to safely participate in the program. The physical exam must have occurred within twelve months of a participant's arrival at camp. **Please bring the completed form with you on Check-in Day.***

**TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER**

*A "licensed healthcare provider" includes licensed physicians (M.D.), physician's assistants (P.A.), and certified nurse practitioners (N.P.) or other healthcare providers licensed by the Commonwealth of Virginia to conduct health examinations.*

**Participant/Camper Name:** \_\_\_\_\_ **BP:** \_\_\_\_\_ / \_\_\_\_\_  
LAST FIRST MIDDLE

**Date of Examination:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **(Exam must have occurred within 12 months of arrival at camp)** **Height:** \_\_\_\_\_ ft \_\_\_\_\_ in

**Date Form Completed:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Date of Last Tetanus Shot:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Weight:** \_\_\_\_\_ lbs

SESSION:

1. Pertinent abnormal medical physical findings:
2. This participant is under the care of a physician for the following conditions:
3. Does the participant have any known allergies?  Yes  No If Yes, please list allergies and treatment below:
4. Will medications be administered to the participant while at camp?  Yes  No If Yes, please list medication, dosage, frequency below:
5. Are any limitations or restrictions placed on activities?  Yes  No If Yes, please list restrictions below:
6. Does the participant have a medically-prescribed meal plan or any dietary restrictions?  Yes  No If Yes, please list restrictions below:
7. Is there any treatment to be continued while at camp?  Yes  No If Yes, please provide treatment instructions below, or attach as separate sheet:
8. Additional information for camp healthcare staff:

FOR CAMP USE NAME(LAST, FIRST):

- In my opinion, the above named participant is able to fully participate in an active camp program
- In my opinion, the above named participant is NOT able to fully participate in an active camp program

Signature of Licensed Healthcare Provider: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

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

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_