MEDICAL CLEARANCE FOR SUMMER 2025

HEALTH CARE RECOMMENDATIONS:

I have examined _____ **on** _____ .
Patient's name date

Height: _____Weight: _____Blood Pressure: _____

In my opinion, the above individual

☐ **is**

☐ **is not**

able to participate actively in camp programs.

If not, describe limitations: _____

_____

The applicant is under the care of a physician for the following conditions: _____

_____

FOR LICENSED PHYSICIAN

Signature: _____ Date: _____

License #: _____ Phone #: _____ Fax #: _____

Date of Physical Exam: _____ By: _____
Sign if completed by nurse or physician's assistant