Camp John Knox HEALTH FORM

Camper's Name _____ Date of Birth _____

Date of Exam _____ Weight _____ Height _____
(This exam must be within the last 12 months prior to attending camp)

Special conditions such as ADD, ADH, etc _____

List Allergies _ _____

Type of reaction _____

In my opinion, the above applicant **is - is not** able to participate in an active camp program.

Description of any limitation or restriction on camp activities _____

The applicant is under my care for the following conditions_____

Treatments to be continued at camp _____

Any medically-prescribed dietary restrictions _____

Any additional information for the care of this camper _____

Signature of Licensed Medical
Personnel_____ Date _____

Printed _____Title _____

Phone # _____ Address _____

Practice Name or stamp:

[Licensed Medical Personnel is physician, physician's assistant or nurse practitioner]