Antiochian Orthodox Christian Archdiocese
Camping Ministry
https://camping.antiochian.org

MEDICAL EXAMINATION FORM FOR SUMMER CAMP

Please make a copy of this form to keep on file for your own reference.

A medical exam is required for the camping session. If an exam was already done within this time period, your physician may be willing to fill out the form without an additional examination. *You may submit a separate Medical Exam/Summary Report from your physician in place of this form if it covers ALL contained information. Check your camp website for the deadline to return this form and any possible late fees.*

Attendee Name _____ *Date of Birth*_____ *Session of Camp attending* ____

This form must be completed by a licensed Physician (MD or DO), Physician Assistant, or Nurse Practitioner

I examined this individual on _____. **BP :** _____ **Weight:** _____ **Height:** _____

Past Medical History *(Medical, Mental Health, Psychiatric, Learning Disabilities, Sensory Issues, etc.)* ☐ Check here if NONE

Treatments / Medications ☐ Check here if NO MEDICATIONS

Name	Dose	Frequency

Activity Restrictions ☐ NO Restrictions while at camp

Allergies / Reactions ☐ No known allergies

Diet/Nutrition List dietary restrictions ☐ Eats a regular diet

Additional information for health care staff at the camp:

PLEASE NOTE: For individuals with severe/anaphylactic allergies, asthma, seizures, diabetes, or other serious medical conditions, there are additional Action Plan forms that are required with more detailed information so that we may adequately care for your child.

In my professional medical opinion, the above applicant ☐ IS ☐ IS NOT able to participate in an active camp program.

Signature of Physician (MD or DO), Physician Asst. or Nurse Practitioner: _____

Printed Name: _____ Date: _____ Phone: _____

Address: _____ Fax: _____ __

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Medical Exam Form for Summer Camp
Immunization Record

Attendee Name _____ *Date of Birth*_____ *Session of Camp attending* _____

Immunization History:** Provide the month and year for each immunization. Starred (*) immunizations must include date to meet ACA Standard. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/ Year	Dose 2 Month/ Year	Dose 3 Month/ Year	Dose 4 Month/ Year	Dose 5 Month/ Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ❑ Had chicken pox Date: _____						
Meningococcal meningitis (MCV4)						

If your camper has not been fully immunized, please sign the following statement:
I understand and accept the risks to my child from not being fully immunized.
Signature of Custodial Parent/Guardian: _____ Date:_____ Relationship to Camper:_____

***You may submit a separate Medical Exam/Summary Report from an approved licensed medical personnel in place of this form if it covers all contained information.*