MEDICAL EXAM FORM
Clemson University Outdoor Lab Clemson, SC 29634-0737
EMAIL: cuolcamps-L@clemson.edu FAX: 864-646-3620

This form to be completed and signed by licensed medical personnel.

Name______________________________ Hgt. ______________ Wt. _____________ B.P. ________________

Circle your camp: Sertoma Hope Odyssey Lions Den Sunshine

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

(For Girls and Women) Has this person menstruated? __________
If so, is her menstrual history normal? __________

Treatment to be continued at camp, please use this chart to list any medications or treatments your child will be taking or be given while at camp:

<table>
<thead>
<tr>
<th>Medicine:</th>
<th>Dosage:</th>
<th>When administered:</th>
<th>Reason for taking:</th>
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Known allergies: _____________________________________________________________________________
Special meal plans or diet restrictions: __________________________________________________________

Limitation or restriction on camp activities: _______________________________________________________

Additional information for camp health care personnel: _______________________________________________

Special considerations: _______________________________________________________________________

I examined this individual on ___/___/_____ (date). In my opinion, the applicant is able to participate in an active camp program.

SIGNATURE OF LICENSED MEDICAL PERSONNEL: ________________________________

Print Name: ___________________________________ Title: ______________________________

Address: _______________________________________________________________________________

Telephone: __________________ Date: __________________

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