

MEDICAL EXAM FORM

Clemson University Outdoor Lab Clemson, SC 29634-0737

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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:

Medicine:	Dosage:	When administered:	Reason for taking:

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.	
<i>SIGNATURE OF LICENSED MEDICAL PERSONNEL:</i> _____	
Print Name: _____	Title: _____
Address: _____	
Telephone: _____	Date: _____