



Physician's Exam or Physical
Camp Cole 2026/2027

Date of physical _____

Parent / Guardian: Please complete the top portion of the form and give to camper's physician to review and complete the bottom portion. This will be uploaded along with their current immunization records to the online application portal.

Camper's Full Name: _____

Person Completing This Form: _____ **Relationship to Camper:** _____

Diagnosis/ Diagnoses: _____ Date of Onset _____

_____ Date of Onset _____

_____ Date of Onset _____

Allergies:

☐ Food _____

☐ Medication _____

☐ Environment _____

☐ Other _____

☐ No Known Allergies

Requires Epi Pen? ☐ YES ☐ NO

Please describe severity of previous reactions: _____

Diet and Nutrition ☐ Eats a regular diet ☐ Has **medically** prescribed meal plan or dietary restrictions (please describe further) _____

Medication or Treatment to be administered at camp? (Include over-the-counter meds regularly given.)

NAME of medication	Dosage	Frequency and Time of Day

☐ No Daily Medications

Please indicate if the camper has had a **problem and/or surgeries** in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory/ Visual/ Speech			
Cardiac			
Pulmonary			
Neurological / Seizures			
Muscular/ Orthopedic			
Learning Disability			
Psychological Impairment			
Gastrointestinal			
Integument (skin)			
Renal			
Other			

The below should be completed by your camper's physician.

Has the camper received all age-appropriate **vaccinations** as recommended by the AAP?

☐ Yes ☐ No, *please explain below if there is a medical reason why this patient cannot receive the vaccinations.* _____

What restrictions (if any) does this camper need to comply with while attending camp? _____

I have reviewed the information completed on this form for accuracy and it is in my opinion that _____ (print camper name) is physically and emotionally fit to participate in an active camp program which includes activities such as archery, farm animal experiences, swimming, sports games, etc. either fully or within the restrictions defined.

Name of licensed provider (please print): _____

Signature: _____ Title: _____

Office Address: _____ Telephone _____