



# Living Water Ministries

Health Examination Form To be completed by a licensed health care provider

Your physician may complete this form based on your child's last visit within 24 months of camp attendance.

Name \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ B/P \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Treatment to be continued at camp:

\_\_\_\_\_

\_\_\_\_\_

Medications to be administered at camp: (name, dose, frequency)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medically prescribed meal plan or dietary restrictions:

\_\_\_\_\_

\_\_\_\_\_

Known allergies, type of reaction, usual treatment:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Activity Restrictions:

\_\_\_\_\_

\_\_\_\_\_

Additional information about any behavior and physical, mental, and emotional problems for the camp health care staff:

\_\_\_\_\_

\_\_\_\_\_

I examined the above named participant on \_\_\_\_\_ and he/she  is  is not able to participate in an active camp program.

**Signature of Health Care Provider** \_\_\_\_\_

Printed Name \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

Phone \_\_\_\_\_ Date \_\_\_\_\_

**For Camp Use Only**

Date Screened _____	Time _____	Updates to health record	Yes	No	N/A
Meds Received _____					
Current Health Care needs _____					
Observation notes _____					
Health Officer signature _____					