Camper Health Evaluation - Spirit Camp

Please print, complete, return this form at least ONE month before camp.

TO BE COMPLETED BY MEDICAL PROVIDER:

Name of Camper: ____

Date of Exam ______________________ (must be within 6 months of camp) Age: ____________

Participation level at camp: Full Participation or Limited Participation (circle one)

Activity Restrictions: ____

Height: ________________ Weight: ___________________ Blood Pressure: _______________

The applicant (camper) is under the care of a physician for the following condition(s): __________

____

____

Current treatment (protocol) at the time of this report: ___________________________________

____

____

Does individual have a history of seizures : Yes or No (circle one)

Date of last seizure: ___________________ Type:________________ Frequency:______________

Recent Surgeries - (dates and type of surgery): ____

____

____

Special concerns or limitations at camp:____

____

Any medically prescribed meal plan or dietary restrictions: ________________________________

____.

Any allergies (food, drug, plants, insects, etc.): ____

Any additional health information: ____

____

Signature of Licensed Medical Personnel: ____

Printed Name: _________________________________ Title: ____________________________

Address: ____ Phone No.________________

Date form completed: _____________ By: ________________ (initial if done on behalf of physician)

Fax to: (605) 328 - 1514 or

Mail to: Spirit Camp, Route #6374, 1305 W. 18th St., PO Box 5039, Sioux Falls, SD 57117-5039