Camp Sun 'N Fun
2024 Physical Examination Form

Camper's Name:_____

Male Female Non-Binary Date of Birth:__Age:_____

Address:_____

City:_____State:_____Zip:_____

Examining Physician:_____

Address:_____

City:_____State:_____Zip:_____Phone:_____

HEALTH HISTORY

Date of Last Tetanus/Booster:_____(Month/Year)

Dates of Covid-19 Vaccine Series': _____ _____ _____

*You must attach a copy of your Covid vaccination record or NJ docket.

DISEASES

	Y	N	Date		Y	N	Date
CoVid-19				Heart Defect/ Disease			
Chicken Pox				Diabetes			
Measles				Bleeding/Clotting Disord.			
Mumps				Hepatitis			
Asthma				Other			

ALLERGIES

	Y	N		Y	N
Hay Fever			Penicillin		
Poison Ivy, etc.			Foods		
Insect Bites			Other		

Food Allergies:_____

Operations or serious injuries (please include dates): _____

_____

Seizure Disorder: Yes or No Type:_____Normal Duration: _____

MEDICAL EXAMINATION

Height:_____Weight:_____T:_____P:_____R:_____BP:_____

Eyes/Nose/Throat: _____

Skin: _____

Musculoskeletal:_____

Mental/Neuro: _____

Cardio & Vascular:_____

Abdomen: _____

MEDICATIONS

Rx and Regular OTC, use separate sheet if needed

Medication	Dose	Route	Frequency	Reason	Date Started

ACTIVITY RESTRICTIONS

	Yes	No
Outdoor Sports		
Sun/Heat Tolerance		
Swimming		
Performing Arts/Dancing		
Nature/Outdoor Activities		
Extensive Walking		

Recommendations or restrictions for any of the above activities while at camp:

_____

_____

_____

To the best of my knowledge, I verify that the above-named camper is physically able to engage in program activities, except as noted above and is free of any contagious or communicable diseases.

_____

Signature of Examining Physician Date

The Arc Gloucester

american camp association ACCREDITED