girl scouts of nypenn pathways

Upload this completed document to your camper's Information Form *(https://bit.ly/Camphealthform)* at least 2 weeks prior to your camp start date.

Questions? Contact info@gsnypenn.org or 1.800.943.4414

2022 PHYSICAL FORM

*We will accept your Doctor's Physical Form also, as long as it was completed **within 12 months** of the camp session.*

Please keep a copy for your records.

Camper's Full Name: _____

Medical Personnel: Please review the Camper Health History Form and complete all remaining sections of this form. Attach any additional information if needed.

TO BE COMPLETED BY A LICENSED PHYSICIAN:

I have examined: Name_____ Date of Exam: _____
Last First Middle

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Birth Date _____/_____/_____ Age _____

PLEASE CHECK YES OR NO. EXPLAIN ALL 'YES' ANSWERS IN FULL

Is the applicant under the care of a physician for any condition(s)? ☐Yes ☐No_____

_____

Is the applicant undergoing treatment at this time for any conditions: ☐Yes ☐No _____

_____

Medications: ☐No medications ☐Will take the following prescribed medications while at camp: (include name, dose, frequency)

_____

_____

_____

Diet, Nutrition: ☐Eats a regular diet ☐Has a medically prescribed meal plan or dietary restrictions: (describe below)

_____

_____

Has there been any reported loss of consciousness, convulsion, or concussion? ☐Yes ☐No _____

_____

Does applicant have epilepsy? ☐Yes ☐No _____

Does applicant have diabetes? ☐Yes ☐No _____

Any treatment to be continued at camp? ☐Yes ☐No_____

_____

Any allergies (food, drugs, plants, insects, etc.)? ☐Yes ☐No _____

_____

Activities to be encouraged or limited? ☐Yes ☐No _____

_____

Additional Health Information: ☐Yes ☐No _____

_____

In my opinion, the above candidate: ☐ Is ☐ Is Not able to participate in an active camp program which may include swimming, canoeing, climbing, and other strenuous activities.

Licensed Physician's Signature _____ Phone (_____)_____

Print Physician's Name _____ Fax (_____)_____

Date of Completion_____By:_____
*Initial if completed by nurse or physician's assistant

Parent/Guardian Signature:_____ Date:_____