

**PLEASE COMPLETE UPLOAD DIRECTLY TO YOUR CAMPDOC ACCOUNT AT LEAST 2 WEEKS
PRIOR TO YOUR CAMP START DATE**

Girl Scouts of NYPENN Pathways
960 James St 2nd Floor
Syracuse NY 13203

PHYSICAL FORM

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

**Please keep a copy
for your records.**

Campers 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 _____

DIRECTIONS: 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 _____

The camper is undergoing treatment at this time for the following conditions: (describe below) ☐ None _____

Medications: ☐ No daily medications. ☐ Will take the following prescribed medications while at camp: (please also complete medication form) _____

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 horseback riding, swimming, canoeing 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:** _____