

PHYSICIAN'S EXAMINATION FORM
Camp Lawrence & Camp Nokomis
To be completed by licensed medical personnel

CAMPER'S NAME: _____ **YEAR:** _____

In accordance with requirements of the State of New Hampshire, children cannot attend a camp program without a record of health examination, completed by an approved licensed medical personal within two years of the camper's arrival at camp.

You may substitute this form with a doctor's office physical form and immunization record.

Name of the Physician: _____ Tel: _____

Address: _____

MEDICATIONS:

- This camper will not take any medications on a daily basis while attending camp
- This camper will take the following medications while at camp:

Name of Medication	Reason for Taking	When is it Given	Dosage	How is it Administered
		<input type="checkbox"/> As Needed <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
		<input type="checkbox"/> As Needed <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
		<input type="checkbox"/> As Needed <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
		<input type="checkbox"/> As Needed <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		

Please identify any current health problems that we need to know about:

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PHYSICIAN

Date of last physical: _____

I attest that this child's immunizations are up-to-date: Yes No Date of last Tetanus _____

BP _____ Height _____ Weight: _____

The above named child may participate in the full camp program without restrictions. Yes No

The above named child may participate with the following restrictions: _____

Signature of Licensed Physician: _____ **Date:** _____