CAMP JOHN KNOX HEALTH FORM **NAME _____**

Camp Session(s) _____

Date of Birth _____ Weight_____ Height _____

Date of Exam _____ **(This exam must be within the last 12 months prior to attending camp)**

Special conditions such as ADD, ADH, etc _____

List Allergies _ _____

Type of reaction _____

In my opinion, the above applicant **is - is not** able to participate in an active camp program.

Description of any limitation or restriction on camp activities _____

The applicant is under my care for the following conditions_____

Treatments to be continued at camp _____

Any medically-prescribed dietary restrictions _____

Any additional information for the care of this camper _____

***Signature of Licensed Medical Personnel**_____ Date _____

Printed _____Title _____

Phone # _____ Address _____

Practice Name or stamp:

*[Licensed Medical Personnel is a physician, physician's assistant or nurse practitioner]