Camper: _____ DOB: _____

PHYSICAL EXAMINATION & HEALTH HISTORY

This Physical Examination form must be completed and signed by a Licensed Physician.

We request this form to be completed no more than 1 year from your camp date to participate in camp.

- Include scan of camper's medical insurance information.
- Please email completed form to: twincitiesrock@gmail.com or mail to Amber Gehring, 7278 Newbury Ct, Woodbury MN 55125

Camper's Legal Name:	**Date of birth:**
Camper's Preferred Name:	**Age (as of July 13, 2025):**
Address:	**Pronouns:**
Primary Phone Number:	**Secondary Phone Number:**

EXAMINATION COMPLETED BY DOCTOR

Diagnoses: Is any condition present which may result in an emergency? If yes, please describe:			
Allergies:			
Does this person carry an epi-pen? YES / NO			**Does this person carry an inhaler? YES / NO**

Height:	Weight:		Lungs:
Pulse:	BP:	Temp:	Cardiac
Head/Scalp:			Upper Extremities:
Eyes:			Lower Extremities/Edema/Circulation:
Vision:			Back/Spine:
Ears/Hearing:			Skin:
Mouth/Throat/Nose:			Nervous System/Pupil Reaction/Reflexes/Gait/Sensations:
Neck/Thyroid & Lymph Sys:			Abdomen:
Free from communicable disease: YES / NO			
PREVIOUS ILLNESS (give age when these occurred): Chicken Pox ☐ Measles ☐ Mumps ☐ Scarlet Fever ☐ Other ☐			
IMMUNIZATION HISTORY: Please give month/year of immunizations and most recent booster dates (or attach immunization records): **Date of last booster: DPT_____MMR_____Tetanus_____ (update if not current)** **COVID-19: 1st Dose_____ 2nd Dose_____ Booster (if applicable)_____** **All Vaccinations are up to date: YES / NO** **If no please explain reason: _____**			

ACTIVITY RESTRICTIONS

List any conditions, operations or known serious injury that may impact camp participation:	
Are there medical reasons to limit or restrict this individual from participating in the swimming program?	**YES / NO** **If yes, please explain:**
Please list any other activity restrictions while individual is participating in camp:	

Camper: ___________________________ DOB: _________

MEDICATIONS:

Please complete with camper's current regimen for both scheduled and PRN medications. No daily medication/vitamin/supplement can be administered at camp unless listed below and signed by a licensed medical professional.

List below medications needed daily while at camp - MUST INCLUDE scheduled over-the-counter medications and vitamins.

Name of Medication:	Reason for taking:	Times given:	Amount/Dose given:	How dose is given:
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
Some common **over-the-counter medications** are stocked in the camp Health Center and may be used on an as-needed basis to manage illness and injury. Please list here if there are any OTC medications that you do not give permission to administer/should be avoided:				

By signing below, I, the camper's physician, certify that the information provided is accurate to the best of my knowledge.

PHYSICIAN'S SIGNATURE: ____

Physician name (please print):	**Date:**
Clinic and address:	**Phone:**