



**PHYSICAL EXAMINATION & HEALTH HISTORY FORM**

Form must be completed and signed by a Licensed Physician no more than 1 year from your camp date to participate in camp.

1. Include scan/photo of medical insurance card
2. Include vaccination record printout/scan
3. Email completed form to: [twincitiesrock@gmail.com](mailto:twincitiesrock@gmail.com) or Amber Gehring, 7278 Newbury Ct, Woodbury MN 55125

Camper's Full Legal Name:	Date of birth:
Camper's Preferred First Name:	Age (as of July 12,2026):
Address:	Pronouns:
	Primary Phone Number:

By signing below, I, the camper's parent/guardian, certify that

- the information provided is accurate to the best of my knowledge,
- routine and emergency medical care may be provided to camper, and
- camp medical staff may contact the camper's physician who completed the form if questions arise.

PARENT/GUARDIAN'S SIGNATURE: \_\_\_\_\_

**EXAMINATION COMPLETED BY DOCTOR**

<b>Diagnoses:</b> Is any condition present which may result in an emergency? If yes, please describe:			
<b>Allergies:</b>			
<b>Does this person carry an epi-pen? YES / NO</b>		<b>Does this person carry an inhaler? YES / NO</b>	
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			
<b>PREVIOUS ILLNESS</b> (give age when these occurred): Chicken Pox ___ Measles ___ Mumps ___ Scarlet Fever ___ Other ___			
<b>IMMUNIZATION HISTORY: Camp R.O.C.K. requires vaccines as recommended by the American Academy of Pediatrics. Attach immunization records or state month/year of immunizations and most recent booster dates:</b>			
All Vaccinations are up to date: YES / NO			
If no please explain reason: _____			
Date of last booster: DTaP/Tdap _____ MMR _____			

**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:
List any other activity restrictions while individual is participating in camp:	

**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 (circle):	Amount/Dose given:	How dose is given:
		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: