



KRISLUND CAMP & CONFERENCE CENTER
189 Krislund Dr., P.O.Box 116 Madisonburg, PA. 16852
Phone: (814) 422-8878 Fax: (814) 422-8552

Name: _____

CAMP PHYSICAL FORM

Camper's name _____ DOB: _____ Gender _____
Address: _____

Medical Provider Statement

I have examined this camper on (Date) _____. The information on this form is accurate to the best of my knowledge. I understand that this camp may involve strenuous physical activities such as climbing, boating, swimming, hiking, and caving.

This camper:

____ May participate in camp without any restrictions.

____ May participate in camp but with certain restrictions as listed on this form:

Medical Provider Signature: _____

Print name: _____

Address: _____

Phone number: (____) _____ Medical License #: _____

Physical Limitations/Restrictions: None

Dietary Restrictions: None

Health History

Are all the camper's recommended childhood vaccinations current? Yes: _____ No: _____

If No, explain:

Last tetanus vaccination: _____

Environmental allergies/Rxn: None

Unit: _____

Year: _____

Campers name: _____

Current medical conditions under treatment:

Current medications:

(All campers who will be taking medications while at camp will need to meet with the camp Health Care Manager)

<input type="checkbox"/>	Medication	Dose	Time to be taken
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			

Check this box if the medication is to be continued while at camp

Medication Allergies: None

Other comments/concerns: