



2026 GMC PHYSICAL HEALTH EXAMINATION

Exam should be completed within the past 24 months and must be signed for participation.

Confidential Information.

Participant's Name: _____

Date of Birth: _____ Camp Sessions Attending (Circle): 1 2 3 4 5 6 7

TO BE COMPLETED BY LICENSED PROVIDER:** Date of Exam: _____
Height: _____ inches / cm Weight: _____ lbs / kg

Check = Normal. If abnormal or notable history, please describe on the line provided.

Medical

- Appearance _____
- Skin _____
- Eyes _____ (Corrected vision: Yes No)
- Ears _____
- Nose _____
- Dental/Oral _____
- Heart _____
- Lungs _____
- Abdomen _____

Musculoskeletal

- Neck _____
- Back _____
- Shoulder/Arms _____
- Elbows _____
- Wrists/Hands/Fingers _____
- Hips/Legs _____
- Knees _____
- Ankles/Feet/Toes _____
- Other _____

Check yes or no as appropriate.

Yes No

Allergies: _____
Allergy Action Plan Yes No (If yes, please attach)

Asthma: _____
Asthma Action Plan Yes No (If yes, please attach)

Diabetes: _____

Seizure disorder/Epilepsy: _____

Reported loss of consciousness or concussion: _____

Mental health concerns (including depression, anxiety, eating disorders): _____

Current treatment(s) and/or medication(s): _____

Other conditions(s) that the camp health supervisor or staff should be made aware of:

This participant is **fully able to participate** in a day or overnight camp program without restriction.

This participant is able to participate in a day or overnight camp program with the following restrictions/recommendations: _____

Licensed Provider's Signature: _____ Date: _____

Printed Name _____ Phone Number: _____

**May be completed by MD, DO, ND, NP, or PA

Initials if completed by RN or MA: _____