Solid Rock Camp and Retreat Center
Medical Examination Form

Name of Camper _____

The State of Colorado requires that this section be completed and signed by a licensed doctor of medicine (M.D. or D.O) or nurse practitioner within twenty-four months of the camp date. Please take this form to the camper's physician to be completed at the time of the examination.

1. Please check the condition of the person being examined in each of the areas listed:

	Normal	Abnormal	Remarks
a. Blood Pressure	□	□	_____
b. Ears	□	□	_____
c. Eyes	□	□	_____
d. Feet	□	□	_____
e. Heart	□	□	_____
f. Lungs	□	□	_____
g. Scalp	□	□	_____
h. Skin	□	□	_____
i. Throat	□	□	_____

3. Tetanus Toxoid: Given: _____ (Date) Needed in case of injury? □ Yes □ No

4. The camper's participation in the program can be: □ Full □Limited

If limited, please explain: _____

_____

5. Other comments or remarks: _____

_____

6. I have examined _____ and found him/her free from communicable diseases.

_____ _____

(Signature of M.D., D.O., or Nurse Practitioner) (Date)

Physician's Name: _____

Physician's Address: _____

City/State/Zip: _____

Phone Number: _____

•Please note that a completed and signed Medication Authorization Form <u>is required for EACH medication</u> (prescription & over-the-counter) your camper will be bringing to camp.