Hollymont Health Exam for Camp Employee

To be completed by Licensed Medical Personnel

To Camp Employee: Complete this section and give this form to your health-care provider.

Employee Name: _____ ☐ Male ☐ Female
First Middle Last

Employee home address:_____ Birth Date _____
Month/Day/Year

_____
City State Zip

Employee phone: (_____)_____ If employee under 18, Parent/Guardian phone: (_____)_____

Employee stop here. Rest of form to be completed by medical personnel.

Medical Personnel: Please complete all remaining sections of this form.
Physician's standard office exam form may be used if comprehensive. **Attach additional information if needed.**

Physical exam done today: ☐ Yes ☐ No (If "No" date of last physical: _____)
Month/Day/Year

ACA accreditation standards specify physical exam within the last 12 months.

Weight _____ lbs Height _____ft _____in Blood Pressure _____/_____

Allergies: Please list & describe reactions ☐ No Known Allergies

☐ To foods ☐ To medications ☐ Other Allergies

☐ To the environment: (insect stings, hay fever, etc.

Medication: ☐ No daily medications.

Will take the following prescribed medication(s) while at camp:
(name, dose, frequency)

The employee is undergoing treatment at this time for the following conditions: (describe below) None ☐

Diet, Nutrition: ☐ Eats a regular diet.

Has a medical prescribed meal plan or dietary restrictions: (describe)

Describe other treatments/therapies to be continued at camp:

Do you feel that the employee will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

I have reviewed the employee's general health and have discussed the camp program with the employee. It is my opinion that the employee is physically and emotionally fit to supervise children and participate in an active camp program (except as noted above.)

Name of licensed provider (please print):_____ **Signature** _____ **Title** _____

Office address: _____
Street City State Zip Telephone: **Date Signed:**