



**SPIRIT CAMP GENERAL
MEDICAL EVALUATION**
(To be completed by family physician by June 19, 2022)



Camper's Name: _____

Diagnosis: _____

Date of Last Exam: _____

Height: _____ Weight: _____

Does individual have a history of seizures: Yes No

Date of last seizure: _____ Type: _____ Frequency: _____

Presently controlled: Yes No

Recent surgeries – (dates): _____

Is individual restricted from: Swimming Other

Special concerns/limitations: _____

Are immunizations up to date: Yes No

Need a copy of your child's immunizations from your family physician.

Date of last tetanus: _____

This should be administered if not up to date - kindergarten and every five years after that.

Does your child have any other medical or mental health concerns: _____

Physician (Printed)

Physician's Signature

Date

