CAMP PROMISE

Camp Promise Physician Form

Camp Promise is a ministry of
Big Sky Bible Camp
501 McCaffery Road, Bigfork, MT 59911
406-837-4864 Email: camppromise@bigskybiblecamp.org

THIS FORM MUST BE COMPLETED BY A LICENSED, PRACTICING PHYSICIAN OR PHYSICIAN'S ASSISTANT

EXAM DATE: ___________ **CAMPER'S NAME:** ____

PRIMARY MEDICAL DIAGNOSIS OF DISABILITY: ____

ADDITIONAL MEDICAL DIAGNOSIS (if any): ____

Height: ____________ Weight: ____________ Pulse: ______ Blood Pressure: _____________

Explain any issues the applicant has in the following areas: If YES, include degree of concern. If NONE, write n/a.

Abdomen: ______________________ Bowels: ________________________ Lungs: ___________________________

Bladder: ________________________ Heart Issues: ___________________ Spine: ___________________________

Does applicant have any history of the following? If YES, explain. Include date of onset. If NO, write n/a.

Asthma: ________________________ High Blood Pressure: _______________________ Base Line ______/______

Diabetes: _______________________ Seizures: ___________________________________

YES or NO (*CIRCLE ONE*) Is applicant in good health, medically stable and cleared by you (attending physician) to attend a multi-day, non-medical camping program.

Give most recent date for each of the following IMMUNIZATIONS/VACCINES:

Tdap: ______ Measles: ______ Tetanus booster: ______ Meningococcal: ______ Hep B: ______ Varicella: ______

MEDICATION or DRUG allergies (or NKDA): ____

MEDICALLY DIAGNOSED FOOD allergies or restrictions that are **MEDICALLY** necessary at camp (or NKA): (Such as dairy, food dyes, eggs, gluten, nuts, etc.) ____

____

OTHER allergies, including **ENVIRONMENTAL** (or NKA): (Such as bee stings, pollen, latex, etc.): _______________________

MEDICALLY NECESSARY EQUIPMENT: (Examples: braces, CPAP, nebulizer, insulin pump, trach, etc.): _________________

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List any **SERIOUS ILLNESS, SURGERY or HOSPITALIZATION** of applicant within the past year: _________________________

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Comments/restrictions regarding attendance at a camp program: ____

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Physician's Signature:___________________________________ Physician's Name (PRINT):___________________________

Office phone: ____ Email address (if available): __________________________