

St. Xenia Orthodox Church Camp

Physician's Consent Form

To be completed by a Physician

(form from your physician's office may be substituted)

This is a required exam **within 24 months of camp attendance and can be submitted by:*

- **Email** (w/attention to the Registrar) to: stxeniacamp@gmail.com
- **Traditional mail** to: **St. Xenia Camp Registrar**
4094 Lusk Rd.
Palmyra, NY 14522

Camper Name

Date of Examination

BP _____ **Weight** _____ **Height** _____

In your opinion, the above applicant is able to participate in an active overnight camp program: ____ **Yes** ____ **No**

The applicant is under the care of a physician for the following reasons:

Recommendations and Restrictions at Camp

Treatment to be continued at camp:

Medications to be administered at camp (name/dosage/frequency):

Any medically prescribed meal plan or dietary restrictions:

Known Allergies:

Description of any limitation or restriction on camp activities:

Additional information for health care staff at the camp:

Signature of Licensed Medical Personnel

Date

Printed Name:

Title:

Email

Phone

Address

Address line 2

City

State

Zip Code

Screening Record: *For Camp Use Only*

Screened By:

Date Screened:

Medications Received:

Updates/additions to health history noted: ___ Yes ___ No ___ None Required

Current health needs identified:

Observational Notes: