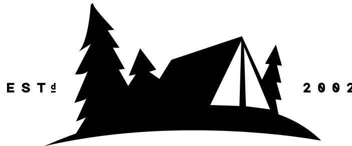


camp get-a-way

77 COMMERCE DR, STE 7, ROCHESTER, NY 14623
PHONE 585/350-9482 FAX 716/604-1962 INFO@CGAW.ORG

Physical completed by: ______________________ **Date:** __________

Doctor's name: ______________________ **Phone:** __________

Applicant's name: ______________________ **Date of birth:** __________

Gender: ☐ Male ☐ Female **Height:** __________ **Weight:** __________

PHYSICAL EXAM *(N= Normal A= Abnormal N/E= Not Examined)*

General Appearance	**N**	**A**	**N/E**	______________
Eyes	**N**	**A**	**N/E**	______________
Ears	**N**	**A**	**N/E**	______________
Nose, Mouth, Throat	**N**	**A**	**N/E**	______________
Heart	**N**	**A**	**N/E**	______________
Abdomen	**N**	**A**	**N/E**	______________
Back, Spine	**N**	**A**	**N/E**	______________
Upper Extremity	**N**	**A**	**N/E**	______________
Lower Extremity	**N**	**A**	**N/E**	______________
Circulatory	**N**	**A**	**N/E**	______________
Neurological	**N**	**A**	**N/E**	______________
Skin, Lymphatic	**N**	**A**	**N/E**	______________
Emotional Status	**N**	**A**	**N/E**	______________

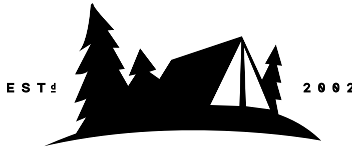
Is there any reason why this person can not participate in any camp activities, such as strenuous walking, walking up / down hills, standing, running, jumping? ☐ Yes ☐ No

If yes, please comment: ______________________

____

____

Physician Signature ______________________ **Date** __________



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MEDICAL INFORMATION RELEASE

I,____, give my permission
NAME OF GUARDIAN

for my provider (____) to communicate with Camp Get-A-Way
PROVIDER NAME

and share medical and health information about ____ that
NAME OF CHILD

will ensure the best camp experience for them.

Signature ____ **Date** ________________