FOUR CORNERS
YOUTH ENCAMPMENT

Four Corners Youth Encampment 2022
Camper Physical Form

▪ PRE-PARTICIPATION PHYSICAL EVALUATION
MEDICAL ELIGIBILITY FORM
Note: to be completed by Medical Physician.

Name of Camper: _____Date of birth: ___/___/____

Date of examination: _____ Sex:_____

• Do you feel stressed out or under a lot of pressure?   YES NO
• Do you ever feel sad, hopeless, depressed, or anxious?   YES NO
• Do you feel safe at your home or residence?   YES NO
• During the past 30 days, did you use chewing tobacco, snuff, or dip? YES NO
• Do you drink alcohol or use any other drugs?   YES NO
• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?   YES NO
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?   YES NO

EXAMINATION

Height:_____ Weight:_____

BP:_____ Pulse:_____

☐ Medically eligible for all sports/activities without restriction

☐ Medically eligible for all sports/activities without restriction with recommendations for further evaluation or treatment of:_____

☐ Medically eligible for certain sports/activities:_____

☐ Not medically eligible for sports/activities pending further evaluation

☐ Not medically eligible for any sports or activities

Recommendations:_____
_____
_____

SHARED EMERGENCY INFORMATION
Allergies/Food Allergies:

_____
_____
_____
_____

Medications: _____
_____
_____
_____

Other information:

_____
_____
_____
_____

I have examined the camper named on this form and completed the pre-participation physical evaluation. The camper does not have apparent clinical contraindications and can participate in the sport(s) and activities as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the camp at the request of the parents. If conditions arise after the camper has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the camper (and parents or guardians).

Name of health care professional (print): _____
_____

Address: _____

Phone: _____

Signature of health care professional_____ ,
MD, DO, NP, or PA

Date:_____