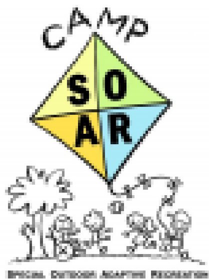

Healthcare Recommendations by Licensed Medical Personnel for Camp SOAR Counselors

Name of applicant:_______________________________________

Counselors must have a physical on file

A copy of ANY physical (sports, school, park district, etc) completed and signed by a licensed medical professional within the past three years can be substituted for this form. Any other form can be emailed to srieger@cr-triangle.org

I have examined the above applicant and in my opinion, she/he ____is ____is not able to participate in an active camp program.

Date of most recent Tetanus____________B/P______________ Weight_________ Height_________

The applicant is under the care of a physician for the following conditions: _________________________________
____

Current treatment at the time of this report includes: ____
____

Recommendation and Restrictions at Camp

Treatment to be continued at camp: ____
____

Medications to be administered at camp (name, dosage, frequency): _____________________________________
____
____

Any medically-prescribed 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:____
Printed: ____ Title:__________________________
Address:____
Phone: ____Date: ________________________________

This form may be sent one of the following ways:
Email: srieger@cr-triangle.org
Fax: 312-726-4021
Mail: 70 E Lake Street, Suite 1300, Chicago, IL 60601
This form must be received in order to attend Camp SOAR