HOPE SHORES
BIBLE CAMP + RETREAT CENTER

Annual Physical Examination Form

***This form must be completed by a physician (MD or DO), PA, Nurse Practitioner (NP) within 12 months of when you begin your job as Camp Staff**.*

Name of Camper: _____ DOB: _____ Sex: M F

Height:_____ Weight:_____ BP:_____ Pulse:_____

Review of Systems:

Skin & Nails _____ Abdomen_____ HEENT_____

Genitalia _____ Neck _____ Musculoskeletal _____

Cardiovascular_____ Neuro_____ Respiratory_____

Lymphatics _____

Restrictions (if any): _____

_____

Any evidence of contagious disease? Yes ☐ No ☐ If yes, please advise:_____

_____

Allergies:_____ Other: _____

_____

I have completed the necessary tests to determine the health condition of this person and find him/her fit to participate in camp activities and serve as a summer Camp Staffer.

SIGNATURE OF PHYSICIAN _____ Date _____