MARYLAND 4-H CAMPS
MEDICAL CLEARANCE FORM

PARENT/GUARDIAN: Complete top portion of this form and attach a copy of your completed Maryland 4-H Camps Health Form. Provide both forms to your child's health care provider for review.

Camper's Name: ____
Last *First* *MI* *Nickname*

☐ Male ☐ Female

Age at Camp Arrival: ______

Birthdate: ______________ *MM/DD/YYYY*

Dates will attend Camp: ______________ to ______________
MM/DD/YYYY *MM/DD/YYYY*

Home Address: ____
Street Address
____
City *State* *ZIP* *County*

PARENT/GUARDIAN requesting medical evaluation:

Name:__________________________ Relationship: ____________________

E-mail: ____

Preferred Phones: #1 ______________________ #2 ______________________
Indicate mobile (M), home (H), work (W)

Home Address: ____
if different from camper *Street Address* *City* *State* *ZIP*

MEDICAL PERSONNEL: Please review the attached Maryland 4-H Camps Health Form, then complete all remaining sections of this form. Attach additional information if needed.

Height: _______ Weight: ___________

Physical Exam done today? ☐ Yes ☐ No

If no, date of last physical exam: ____________________

Allergies: (check and list)
☐ No known allergies
☐ Foods ______________________________
☐ Medicines ______________________________
☐ Environment ______________________________
☐ Other ______________________________

Describe previous reactions for noted allergies:

Diet/Nutrition: ☐ Eats a regular diet ☐ Has medically-prescribed meal plan or dietary restrictions *(describe below).*

Current Health Issues: ☐ No current treatment ☐ Child is currently being treated for the following conditions *(describe below)*:

Medication: ☐ No daily medications ☐ Child will take the following medications while attending camp *(describe below; - name, condition treating, dose, frequency)*:

Other Treatments/Therapies: ☐ None needed ☐ Child should continue therapy/treatment while at camp *(describe below)*:

University of Maryland Extension programs are open to all and will not discriminate against anyone because of race, age, sex, color, sexual orientation, physical or mental disability, religion, ancestry or national origin, marital status, genetic information, political affiliation, or gender identity and expression.

Is Camper's participation in camp activities limited or restricted by any medical condition, therapy, or treatment?

☐ No restrictions or limitations

☐ The following medical restrictions or limitations should be observed *(describe below—attach additional information if needed)*:

PHYSICIAN'S RECOMMENDATION: I have reviewed the Maryland 4-H Camps Health Form and the child's medical history, and I have discussed the camp program with the child's parent/guardian(s). It is my opinion that the child is physically and emotionally fit to participate in an active camp program, with any restrictions or limitations noted above.

Printed Name of Physician: ______________________ **Physician's Signature:** ______________________ **Date:** ____________

Office Address and Phone:

____
Practice Name *Phone #*

____
Street Address *City* *State* *ZIP*

University of Maryland Extension programs are open to all and will not discriminate against anyone because of race, age, sex, color, sexual orientation, physical or mental disability, religion, ancestry or national origin, marital status, genetic information, political affiliation, or gender identity and expression.