

## PHYSICIAN REFERRAL

Please note the "Physician Referral" form must be completed by a physician/nurse practitioner. If this form is not completed in its entirety, the youth will not be able to participate in activities at the Alabama 4-H Center.

(\*\*to be completed by a physician/nurse practitioner having had the exam within the last 24 months\*\*)

Camper Name: \_\_\_\_\_ Summer Camp Session \_\_\_\_\_

Date of last physical exam (**must be within past 24months**) \_\_\_\_/\_\_\_\_/\_\_\_\_

Description of any camp activity (i.e. climbing wall, high ropes elements, swimming, caving, hiking, general spots activities) from which camper should be exempted due to health reasons/limitations

In my professional opinion, this individual,

\_\_\_\_\_ Should be allowed to participate in an active camp program at the Alabama 4 H Center

\_\_\_\_\_ Should **NOT** be allowed to participate in an active camp program at Alabama 4 H Center

This camper is under my care for the following condition(s):

\_\_\_\_\_  
\_\_\_\_\_

Treatment to be continued at camp:

\_\_\_\_\_  
\_\_\_\_\_

Medications to be administered at camp (name, dosage, frequency) including OTC medications

\_\_\_\_\_  
\_\_\_\_\_

Medically prescribed meal or dietary restrictions

\_\_\_\_\_  
\_\_\_\_\_

Known allergies (food, environmental, medications)

\_\_\_\_\_  
\_\_\_\_\_

Date of recent tetanus shot \_\_\_\_\_

**Printed Name (of physician / nurse practitioner)** \_\_\_\_\_

Title \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

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