

# Black Rock Retreat Special Week Doctor's Form

1345 Kirkwood Pike, Quarryville, PA 17566 / 717.529.3355 / [www.blackrockretreat.com](http://www.blackrockretreat.com)



Exam Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Applicant's Name \_\_\_\_\_

Primary Medical Diagnosis \_\_\_\_\_

Additional Medical Diagnosis (If Any) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_/\_\_\_\_ Respirations \_\_\_\_\_

Please explain any symptoms/issues the applicant has in the following areas- including degrees of concern:

Eyes _____	Circulation _____	Bowel _____
Ears _____	Lungs _____	Genitalia _____
Nose _____	Lymph nodes _____	Extremities _____
Mouth _____	Abdomen _____	Back/Spine _____
Throat _____	Hernia _____	Skin _____
Teeth _____	Intestinal _____	Other _____
Heart _____	Bladder _____	_____

## Immunizations (Give Most Recent Date)

DTaP \_\_\_\_\_ MMR \_\_\_\_\_ Polio \_\_\_\_\_ Hep B \_\_\_\_\_ Varicella \_\_\_\_\_  
Meningococcal \_\_\_\_\_ Tetanus Booster \_\_\_\_\_ TB \_\_\_\_\_ (Pos) (Neg) COVID-19 \_\_\_\_\_

List Applicant's MEDICATION Allergies (or NKA) \_\_\_\_\_

List Applicant's FOOD Allergies (or NKA) \_\_\_\_\_

List Any OTHER Allergies, Including ENVIRONMENTAL \_\_\_\_\_

MEDICALLY PRESCRIBED DIETARY NEEDS or RESTRICTIONS \_\_\_\_\_

MEDICALLY NECESSARY EQUIPMENT \_\_\_\_\_

List Any SERIOUS ILLNESS, SURGERY, or HOSPITALIZATION of Applicant Within the Past 12 Months

\_\_\_\_\_

General Appraisal of Applicant \_\_\_\_\_

\_\_\_\_\_

**DOCTOR'S CLEARANCE FOR PARTICIPATION:** Is this applicant in good health, medically stable, and cleared by you (attending physician) to attend an overnight, multi-day, outdoor, non-medical camping program?    **YES**    **NO**

**Comments/Restrictions concerning attendance at a camp program** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Physician's Name (Print) \_\_\_\_\_

Office Phone \_\_\_\_\_ Email (If Available) \_\_\_\_\_