



HANDI*CAMP PHYSICIAN'S FORM



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THIS MUST BE COMPLETED BY A LICENSED, PRACTICING PHYSICIAN

APPLICANT'S NAME _____

PRIMARY MEDICAL DIAGNOSIS _____

ADDITIONAL MEDICAL DIAGNOSIS (if any) _____

Height _____ Weight _____ Pulse _____ Blood pressure _____

Eyes _____ Lungs _____

Glasses? _____ Contact lenses? _____ Lymph nodes _____

Ears _____ Abdomen _____

Nose _____ Hernia _____

Mouth _____ Genitalia _____

Throat _____ Extremities _____

Teeth _____ Posture (spine) _____

Heart _____ Skin _____

General Appraisal _____

Additional comments/restrictions _____

In my opinion, applicant (circle one) **IS / IS NOT** able to participate in an overnight camping program designed for persons with physical disabilities.

Physician's signature _____ Date _____

Physician's Name _____

Office Address _____

City _____ Province _____ Postal Code _____

Office Phone () _____