2026 Camp Trinity Physical Form:
TO BE COMPLETED BY A LICENSED PHYSICIAN

P. O. Drawer 380, Salter Path, NC 28575
EMAIL: nreynolds@trinityctr.org

Camper Name:_____ Camp Session: _____

PLEASE NOTE: A health history/examination form must be completed and sent into the camp office **EACH YEAR** by a parent or guardian **30 days** before admission to a camp session. A physician's examination for some other purpose within the past year is acceptable **if** the information requested on that form is the same as for this request. Examination is necessary in case of illness or accident and to determine fitness to engage in all camp activities.

IMMUNIZATION HISTORY: (Dates of basic immunizations/most recent booster doses OR attach shot records to form)

DTP/DTaP _____Booster _____ MMR_____ _____
Td/TDAP _____Booster _____ Tuberculin Test_____
Polio Series_____ Booster _____ Varicella (disease)_____ vaccine _____
Hep B Series _____ Hep A_____ Menactra _____

GENERAL APPRAISAL:

Height _____ Weight_____ BP _____
Eyes_____ Glasses/contacts_____ Nose _____
Teeth_____ Braces_____ Throat _____
Ears _____ Heart _____
Speech_____ Hearing_____ Lungs _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

The applicant is under the care of a physician for the following condition(s):_____
_____
Current treatment to be continued at camp_____
_____
Specific medications: prescription and OTC, to be administered at camp_____
_____
Swimming _____
Strenuous activity (describe)_____
Dietary restrictions_____
Allergies(food, drugs, plant, insect)_____
Description of any current physical, mental, emotional, social health, developmental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp?_____
_____
Description of any camp activities the camper should be exempted from for health reasons?_____
Additional health information_____
_____

Licensed Physician's Signature
I have examined the person described herein and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

_____ _____ _____
Signature of Examining Physician Date (Please print or type name)

(____)_____-_____ _____ _____ _____
Telephone City State Zip

Date form completed_____ *By_____
*Initial if completed by nurse or physician's assistant

A note to parents: Please notify the camp nurse **at check - in** if the camper has been exposed to or exhibits any symptoms of a communicable disease during the **three weeks** prior to camp attendance. Do not bring a sick child to camp. We reserve the right to send campers home who are sick on arrival.