



THIS FORM IS TO BE COMPLETED AND SIGNED BY A LICENSED MEDICAL PROFESSIONAL

First Name _____ **Last Name** _____

I last examined the individual listed above on the following date: _____

Height: _____ Weight: _____ Blood Pressure: _____

The individual is under the care of a physician for the following conditions:

Current treatment and/or medications at the time of this report includes:

Treatment and/or medications to be administered at camp or on tour:

Additional information for health care staff at camp or on tour:

I attest that the medical information provided on this form is substantively correct.

In my opinion, this individual is is not able to participate in an active camp or concert tour program.

Signature: _____ Date: _____

Printed Name: _____ Title: _____