



MEDICAL EXAMINATION FORM
ORLANDO IBD CAMP 2026

THE EXAMINATION TO BE COMPLETED BY A LICENSED PHYSICIAN (OR PHYSICIAN EXTENDER, SUCH AS APRN OR PA) NO MORE THAN 90 DAYS BEFORE THE START OF CAMP.

Childs Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Diagnosis \_\_\_\_\_

Type of hearing loss (e.g., sensorineural, conductive, mixed) \_\_\_\_\_

Other Medical Diagnoses:

\_\_\_\_\_

Allergies:

\_\_\_\_\_

\_ Please describe any current medical problems (other than IBD):

Physical Exam significant findings:

Medications:

Table with 4 columns: Name, Dose, Route, Frequency. Includes three rows of blank lines for data entry.

Is the child's development appropriate for his/ her age? Y / N

If no, at what age does he/she function? \_\_\_\_\_

Pertinent psychosocial information, including any behavior problems that may affect child's participation in a group

\_\_\_\_\_

\_\_\_\_\_

Please specify any camp activity restriction(s) \_\_\_\_\_

**EXAMINING PHYSICIANS STATEMENT**

I have examined this child and his/her medical history and find that he/she is able to attend ORLANDO IBD CAMP and participate in the activities except as noted above. I understand that the above treatment plan will be followed at camp unless other orders are received.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Name (print): \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_

**(Please print)**