



Cheley Colorado Camps 2025 Health Form

DUE MAY 1
Must be completed by a licensed medical professional approved to perform physical exams. Upload completed form to CampBrain account or email to office@cheley.com.

Name: _____

Birthdate (DD/MM/YYYY): _____

Male Female First Term Second Term Quarter B-4

To be completed by a physician:

Date of last physical exam: _____ Height: _____ Weight: _____ Blood Pressure: _____

Conditions
List conditions for which the patient is receiving treatment

Treatments/Medications (please include OTC if taken regularly)
List treatments/meds to be used at camp: name/dose/frequency

Restrictions: List activity restrictions

Diet/Nutrition: List dietary restrictions

Past Medical/Surgical History

Allergies: List all allergies and reactions

Physician Authorization: I have reviewed the patient's health history and have discussed the camp program with the parent/guardian. I find the patient physically/emotionally fit to participate in an active camp program, except as noted above.

Name: _____ Signature: _____ DATE: _____

Address: _____ City: _____ State: _____ Zip: _____