Results of Annual Exam by Medical Doctor

Camper Last Name: _______________________________ First Name: ____

DOB: _______________________

The patient named above has registered to attend an overnight summer camp program with the Autism Society of Minnesota. Parents have completed an online medical history, including diagnoses, prescribed medications, and treatment protocols. We are asking your clinic to certify that this camper has been examined by a licensed physician or nurse practitioner within the previous twelve (12) months.

Date of last physical exam: _______________________ Height: ________________ Weight: _________________

Does this camper have any activity restrictions? Y _____ N ______

Please share any concerns you have with this person attending an ADA and ACA-certified summer camp.

Name of Provider or Prescribing Doctor (MD/DO/PA-C/NP): ____

Phone number: _____________________ Signature: ____

This form may be faxed directly to AuSM Summer Camps

ATTN: Melinda Harris, Director

651 – 642 - 1230