

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
DATE OF EXAM

Town of Amherst  
Medical Exam Report  
A physician should fill out this form.  
Please Print Clearly

Participants Name: \_\_\_\_\_

Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Date of Birth \_\_\_\_\_

Personal History

Check box beside those medical problems above child has had or currently has. If a box is checked for any below please explain\*.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Fainting Spells              | <input type="checkbox"/> Mild/Severe Ankle Issues  |
| <input type="checkbox"/> Back Problems             | <input type="checkbox"/> Head Injuries                | <input type="checkbox"/> Mild/Severe Knee Issues   |
| <input type="checkbox"/> Bleeding Disorders        | <input type="checkbox"/> Hearing Impairment /Deafness | <input type="checkbox"/> Seizure Disorder/Epilepsy |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Problem or Murmur      | <input type="checkbox"/> Speech Impairment         |
| <input type="checkbox"/> Vision Problems/Blindness | <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> ADD/ADHD                  |
| <input type="checkbox"/> Autism                    | <input type="checkbox"/> Developmental Disability     | <input type="checkbox"/> *Other                    |

\*Explain: \_\_\_\_\_

Allergies: Check and explain reaction/treatment

- |  |       |
|--|-------|
| <input type="checkbox"/> Medicines     | _____ |
| <input type="checkbox"/> Food          | _____ |
| <input type="checkbox"/> Animals       | _____ |
| <input type="checkbox"/> Insect Stings | _____ |

Is the participant currently taking any medication?

- Yes  
 No

If Yes, Please Explain \_\_\_\_\_

Any Special limitations (surgeries, injuries not listed above, etc.) \_\_\_\_\_

I examined \_\_\_\_\_ on \_\_\_\_\_ and find him/her in good health and able to participate in Amherst Leisure Services Sports Camps, Outdoor Challenge Camp and/or other physical activities.

Physicians Name: \_\_\_\_\_

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Form is not complete until signed.