



ASCEND SPEECH & DEBATE

# Medical Personnel Accuracy Verification

To be completed by licensed medical provider

Medical Personnel: Please review the information submitted for the camp attendee named below for accuracy and complete the fields below for our licensed medical staffer. Questions? Contact us at [info@ascendspeech.org](mailto:info@ascendspeech.org).

## 1 Physical Examination Data

CAMPER NAME

Full legal name

DATE OF LAST PHYSICAL EXAM

mm/dd/yyyy

WEIGHT (LBS)

—

HEIGHT (FT)

—

HEIGHT (IN)

—

BLOOD PRESSURE

—/—

## 2 Allergies

Is the provided information pertaining to **allergies** accurate?

Yes

No

LIST ALL ALLERGIES, CONCERNS, CONSIDERATIONS & PREVIOUS REACTIONS

If none, write 'None'



3

### Dietary Restrictions

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Is the provided information pertaining to a **special diet** accurate?

Yes  No

MEDICALLY PRESCRIBED MEAL PLAN OR DIETARY RESTRICTIONS

If none, write 'None'



4

### Medications

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Is the information pertaining to **prescribed medication** accurate?

Yes  No

OVER-THE-COUNTER MEDICATIONS OR TREATMENTS THE CAMP HEALTH DIRECTOR SHOULD PROVIDE

If none, write 'None'



Are there any **treatments or therapies** that need to be continued at camp?

Yes  No

DESCRIPTION (IF YES)

Describe any ongoing treatments or therapies

**Note:** Ascend Speech and Debate is *not* a camp based in physical activities. Daily, nothing more strenuous than walking short/medium distances will be required of campers.

With the above in mind, will the camper require any **restrictions, limitations, accommodations, or modifications** at camp?

Yes  No

DESCRIPTION (IF YES) — ATTACH ADDITIONAL INFORMATION IF NECESSARY

Describe any required restrictions or accommodations

SIGNATURES & ATTESTATION

LICENSED PROVIDER

After reviewing the above information and discussing the camp with the parents/guardians, please sign below if you are of the opinion that the camper is physically and emotionally fit to attend camp, other than what you have noted above. You attest that the information provided is accurate and has your professional endorsement.

NAME OF LICENSED PROVIDER (PRINT)

Full name

OFFICE PHONE NUMBER

(\_\_\_) \_\_\_-\_\_\_\_

OFFICE ADDRESS

Street, City, State, ZIP

DATE

mm/dd/yyyy

Signature of Licensed Provider

PARENT / GUARDIAN

Please sign below to attest that all information provided is accurate, complete, and correct.  
Questions? Contact [info@ascendspeech.org](mailto:info@ascendspeech.org).

PARENT / GUARDIAN NAME (PRINT)

DATE

Full name

mm/dd/yyyy

Signature of Parent / Guardian