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 diagnosis (e.g.,Crohn's, UC, Indeterminate, VEO) ___________________

Other Medical Diagnoses:

____

Allergies:

____

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

Physical Exam significant findings:

Medications:

Name	Dose	Route	Frequency
_______________	_______________	_______________	_______________
_______________	_______________	_______________	_______________
_______________	_______________	_______________	_______________

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

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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)