MOUNTAINEERS

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Physician's Report

First Name: _____ Last Name _____

Date of Birth: _____ Age as of 07/31: _____

Address: _____

City: _____ ST _____ Zip _____

Date of Exam: _____ Height: _____ Weight: _____

Blood Pressure: _____ Vision: _____

Medical History, medications, allergies, respiratory problems, etc: _____

Comments/Medical Concerns:

Physician's Name: (*Please Print*) _____

Physician's Signature: _____ Date: _____

Physician's Phone Number: _____

Important: Please attach a copy of Birth Certificate. Originals not needed.