

Camp Name _____ Dates of Camp _____

Today's Date _____



**Experiential Learning
Associates**

Youth | Teachers | Science | Leadership

TO: Medical Personnel

FROM: Experiential Learning Associates Wilderness Journeys Program

RE: Immunization Records + Proof of physical within 24 months of camp start date

Feel free to use the form provided or your own form.

Experiential Learning Associate Wilderness Journeys is licensed through the Colorado Department of Human Services to run overnight trips. State law requires that we receive confirmation on potential camper's health, immunization record and physical within 24 months of the trip start date.

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Student Full Name _____

Gender: M F **Date of Birth** _____ / _____ / _____ **mm/dd/yyyy**

_____ **Certificate of Immunization Attached**

RELIGIOUS EXEMPTION: Parent or guardian of the above named child is an adherent to a religious belief opposed to immunizations.

Parent Signed _____ Date _____

I have examined this student and found her/him to be in good physical condition. He/she is capable of active participation in an overnight camping program. This includes hiking, rafting, beginner rock climbing, sleeping outdoors in tents or tarps, carrying a daypack and other moderate outdoor activities. ***The exception to the above is attached on a separate sheet _____ (please check if applicable).***

DOCTOR'S PRINTED NAME _____
First Last

Address _____ **Phone** _____
City State Zip

X _____ **Date** _____
Signature of Physician or Nurse Practitioner

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