



**MEDICAL EXAMINATION FORM
ORLANDO COCHLEAR IMPLANT 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 Hearing Loss Diagnosis _____

Type of hearing loss (e.g., sensorineural, conductive, mixed) _____

Other Medical Diagnoses:

Allergies:

Please describe any current medical problems (other than hearing loss):

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

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 COCHLEAR IMPLANT 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)