CAMPER NAME: _____ SESSION ATTENDING: _____

◆THE INFORMATION ON THIS PAGE IS TO BE FILLED OUT BY YOUR PHYSICIAN◆
HEALTH FORMS FROM OTHER ORGANIZATIONS OR SCHOOLS CANNOT BE ACCEPTED

Health Care Recommendations and Annual Physical Information by Licensed Medical Personnel

I examined this individual on _____ Exam date MUST fall within 12 months of camp attendance

Blood Pressure _____ Weight _____ Height _____

In my opinion, the above participant ☐ Is ☐ Is Not able to participate in an active camp program.

The participant is under care for the following conditions _____

_____

Recommendations and Restrictions by Licensed Medical Personnel

Treatment to be continued at camp _____

Meds to be administered at camp (name, dosage, frequency) _____

_____

Any medically prescribed meal plan or dietary restrictions _____

Known allergies _____

Description of any limitation or restriction _____

Additional information for camp health care staff _____

_____

_____

Immunization Information ◆ Mandatory Information, Please fill out completely ◆

Date of participant's last tetanus shot _____
Check here if participant has never had a tetanus shot _____
Please list if the participant has had any of the following diseases **and/or their most recent immunization date** for each:

Influenza (type b) _____
Chicken pox _____
Measles _____
Mumps _____
Hepatitis A _____
Hepatitis B _____

Hepatitis B _____
Hepatitis C _____
Pneumonia _____
Meningitis _____
Tuberculosis test date _____ positive or negative

Are participant's other immunizations current, if no, why _____

Signature of Licensed Medical Personnel ◆ Mandatory Information, Please fill out completely ◆

Signature of Licensed Medical Personnel _____

Printed Name _____ Today's Date _____

Address _____ Phone Number _____

Camp Staff Use Only

Date Screened _____ Normal Check-in time ☐ Late Arrival ☐

Meds turned in to health center staff? Yes ☐ No ☐

Updates or additions to health history noted? Yes ☐ No ☐ None Required ☐

Lice Check ☐

Screened By _____ Additional Notes _____