Name ________________________________ Date of Birth _____/______/____ Phone _________________
Guardian _____________________________________ Address ____________________________________
Emergency Contact ____ Phone _____________________

--------------------------- TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTIONER ---------------------

Date of Exam _____/_____/________

_____ May participate in all camp activities
_____ May participate except for: ____

Medical information pertinent to routine care and emergences: ___________________________________

Is this individual taking prescription or over the counter medication(s): ☐ Yes ☐ No If yes, please indicate:
____

Does this individual have special needs? ☐ Yes ☐ No Explain: ___________________________
Is this individual on a special diet? ☐ Yes ☐ No Explain: ___________________________

This camper is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Comments:
____
____

Print Name of Medical Provider: ____
Medical Provider's Address: ____
Medical Provider's: City/Town _________________________________ State ________ Zip Code __________

____
Signature of Physician, PA, APRN or RN

____
Date Form Signed

____
Telephone Number