

CAMPER MEDICAL FORM

*(Must be completed and signed by **Specialist**)*

Camper's Name: _____ DOB: _____ Wt.: _____

Primary Diagnosis: _____ Date of Diagnosis _____

Other Diagnoses: _____

Allergies: _____

Please describe any **current medical problems**. _____

PHYSICAL EXAM significant findings _____

MEDICATIONS

Name:	Dose:	Route:	Frequency:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is the child's development appropriate for his/her age? Yes No

If no, at what age does s/he function? _____

Pertinent Psychosocial Information, including any behavior problems that would affect child's participation in a group.

Please specify any camp activity restrictions _____

Physician's Statement: I have examined this child and find him/her physically able to attend camp.

I understand that the above Treatment Plan will be followed at camp, unless other orders are received.

A copy of the most recent OFFICE NOTES must also be sent to Camp Boggy Creek

Signature of MD/ARNP/PA

Print Name

Date

Treatment Center

Emergency number

Fax number

MD/ARNP/PA email address

(Camp Boggy Creek fax 352-483-2959)

