CAMPER MEDICAL FORM

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

Camper's Name:____________________________________DOB:______________Date of Diagnosis.:_________
Primary Diagnosis:____
Other Diagnoses:____
Mental Health Diagnoses (including any recent hospitalizations for mental health):___________________________
____

Has the Camper been diagnosed with Autism? ❍ **Yes** ❍ **No**

Allergies:____

Please describe all **current medical problems**: ____
____

******<u>A copy of the most recent Office/Clinic Visit Notes must also be sent to Camp Boggy Creek</u>******

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 Mental Health Information, including behavior problems that would affect child's participation in a group:
____

Please specify any camp activity restrictions:____
____

Provider Statement: I have examined this child and find him/her physically/mentally able to attend camp. I understand that the above Treatment Plan will be followed at camp, unless other orders are received.

______________________	______________________	______________
Signature of Specialist	**Print Specialist Name**	**Date**
______________________	______________________	______________
Treatment Center	**Emergency number**	**Fax number**

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Specialist's email address

(Camp Boggy Creek fax 352-483-2959)