

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**: _____

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

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

Specialist's email address



(Camp Boggy Creek fax 352-483-2959)