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)