CAMPER MEDICAL FORM

(To be completed and signed by ***Primary Care Physician)***

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**: ____

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.

Primary Care Physician Signature	**Print PCP's Name**	**Date**
Treatment Center/Practice Name	**Emergency number**	**Fax number**

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PCP's email address

(Camp Boggy Creek fax 352-483-2959)