CAMP WEEKANEATIT 2020 Camp Weekaneatit Camper Medical Form

Patient/Camper Name _____
Date of Exam _____

Height _____ Weight_____ BP _____

Current Physical and Medical
Condition _____
_____
_____
_____

Current Treatments
_____
_____
_____
_____

Please list all allergies or indicate NONE if applicable
Medication Allergies:

Environmental Allergies:

Other Allergies:

Food Allergies: LIST BELOW

Please list the **medically-prescribed** meal plan, or indicate NONE if applicable
_____
_____
_____

Please list all food allergies and reaction (ALL OF THESE WILL ALSO BE REFLECTED ON THE SEVERE ALLERGY FORM SIGNED BY A LICENSED ALLERGIST):

ALLERGY	REACTION

Page 2 Patient/Camper Name _____

Description of any limitation, concern, or restriction on camp activities
_____
_____
_____

Please indicate if camper is currently or in past 12 months has been under care of a mental health care provider (If YES, family will be required to have mental health provider to complete/sign additional form—please request form)

Yes No

Please list all medications the patient/camper takes (including drug/dosage/frequency)
_____
_____
_____
_____

The camper's vaccinations are up to date: Yes No

and, I have supplied the up to date written immunization records.

I hereby verify that the information on this form concerning health matters and medications is correct. In my opinion, this child is able to participate in Camp Weekaneatit 2020.

Physician's Signature _____
Physician's Name (please print) _____
Address_____**Phone Number** _____