MEDICAL FORM

This page to be completed by family physician or pediatrician

GENERAL INFORMATION

Camper Name: _____

Camper illness: _____

City: _____ State: _____ Zip: _____

Age: _____ Birth date: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Phone: _____

Current Specialty Physician: _____ Phone: _____

Medications to be taken routinely (include non-prescription): _____

_____

_____

Allergy to foods, medications and other: _____

_____

Baseline physical findings: _____

Baseline vital signs: _____

Baseline neurological status: _____

Prosthesis/ Appliances: _____

Explain any restriction to activities: _____

_____

IMMUNIZATIONS

TB skin test: Pos Neg. TB Skin test date: _____

Are all immunizations up to date? YES NO

Are immunizations records on file at physician's office? YES NO

PHYSICIAN'S ACKNOWLEDGEMENT: I have been informed about Dream Day Camp Nan-Ke-Rafe and the request of my patient to attend. The items are correct to the best of my knowledge and belief. In my opinion, this patient is physically capable of attending Camp Nan-Ke-Rafe.

_____ _____

Signature of Physician Date

_____ _____

Please print name Phone