SUMMER CAMP MEDICAL HISTORY FORM QUALIFYING CHILD

Must be Completed by Physician

Dream Day on Cape Cod, 165 Nan Ke Rafe Path Brewster, MA 02361

A new Medical History form must be submitted each camp year.

Camper Name:____ (Preferred Name):____

Date of Birth: __________________ Age at camp:________________

Mother/Guardian Name:________________________________ Father/Guardian Name: __________________________________

Home Address:____

Street City State Zip

Home Phone:_____________________ Daytime Phone: ____________________ Cell Phone: _____________________________

Family Emergency Contact:____ Phone:____

If not available in an emergency, notify:

Name:___________________________________ Relationship: _____________________ Phone:___________________________

ALLERGIES List all known medical and food allergies.

SPECIAL DIET If child requires any special dietary needs/requests.

Please give the most recent immunization dates for the following if applicable:

Tetanus______________________ MMR_____________________________ Hepatitis B____________________

DPT Series _________________________ Covid 19 _____________________

Baseline vital signs: ___________________________

Baseline neurologic status: ______________________

Prosthesis/Appliances: _________________________

Explain any restrictions of participation in full camp/activities:____

____

Name of participant's pediatrician or family doctor: ____

Office Phone :__________________________ Address: ____

Physician's Acknowledgement:

I have been informed about Dream Day on Cape Cod summer camp located at 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 Dream Day Camp located at Camp Nan-Ke-Rafe.

Physician Signature: ____

Additional notes: