Summer Camps at College Settlement

2019 Camper Medical Form 2

Send to: 600 Witmer Road, Horsham, PA 19044 215-542-7974
email to: upload@collegesettlement.org www.collegesettlement.org

MUST BE SUBMITTED 4 WEEKS PRIOR TO CHILD'S CAMP SESSION

To be filled out by Licensed Physician

Session will attend camp: _____

Child Name: _____ ☐ Male ☐ Female Birth date: _____

Child's Address:_____

Physical exam done today: ☐ Yes ☐ No (if "no" date of last Physical: _____

ACA accreditation standards specify physical exam within last 12 months.

Weight: _____lbs Height: _____ft_____in Blood Pressure: _____/_____

Allergies: ☐ No known Allergies

☐ Food (list):_____

☐ To Medications: (list):_____

☐ To the environment (list):_____

☐ Other allergies: (list):_____

Please describe reactions:

_____

_____

_____

Diet, Nutrition: ☐ Eats a regular diet ☐ Has a medically prescribed meal plan or dietary restrictions: (describe below)

_____

_____

The child is undergoing treatment at this time for the following conditions: (describe below)

_____

_____

Medication: ☐ No daily medications ☐ Will take the following prescribed medication(s) while at Camp: (name, dose, frequency)

_____

_____

Other treatment/therapies to be continued at Camp: (describe below) ☐ None needed.

_____

_____

Do you feel that the child will require limitations or restrictions to activities while at Camp? ☐ Yes ☐ No (if yes, what do you recommend)

_____

_____

"I have discussed the Camp program with the child's parent/guardian. It is my opinion that the camper is physically and emotionally fit to participate in an active Camp program (except as noted above)"

Name of licensed provider (print):_____ Signature: _____ Title: _____

Office Address: _____ Phone #:_____

Date: _____

SEE REVERSE FOR IMMUNIZATION HISTORY

Camper Last Name:---------- Camper First Name ---------- (for camp use) Unit:---------- (for camp use) Session:----------

TO BE SUBMITTED AT LEAST 4 WEEKS PRIOR TO CHILD'S CAMP SESSION

<u>Immunization History</u>: Provide the month and year for each immunization. If child is not immunized please sign waiver below.
Copies of immunization forms from health-care providers or state or local government are acceptable; please attach printout to this form.

Immunization	Most Recent Dose Month/Year	Immunization	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)		Tetanus booster (dT) or (TdaP)	
Mumps, measles, rubella (MMR)		Polio (IPV)	
Haemophilus influenzae type B (HIB)		Pneumococcal (PCV)	
Hepatitis B		Hepatitis A	
Varicella (chicken pox) ☐ Had chicken pox Date:		Meningococcal meningitis (MCV4)	
Tuberculosis (TB) test:	Date:	☐ Negative ☐ Positive	

If your camper has NOT been fully immunized, please sign the following statement. I understand and accept the risks to my child from not being fully immunized.

❖ Parent/Guardian _____Date:_____