Last Name	First Name	Birth Date
	Steve Testing	

Upload: to your camp account
OR
Email: forms@campdina.com
OR
Mail: 5515 New Utrecht Ave.
Brooklyn, NY 11219

Camp Dina Medical Form — Parent's Page

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Mother's Cell: _____

Father's Cell: _____

In case of emergency, if a parent is not available, contact:

Name: _____ Phone: _____

Physician: _____ Phone: _____

Medications to be continued at Camp (name, strength & dosage):

Campers who take daily medication are required to use J Drugs, a pharmacy who supplies pre-packaged medications, for their medication. Please download the form from our website and order your medication from J Drugs directly.

Would you like us to be aware of anything to assist us in caring for your child?

Please tape a copy of the **FRONT** of your **INSURANCE CARD** here.

Please tape a copy of the **FRONT** of your **PRESCRIPTION CARD** here. (if different)

Please tape a copy of the **BACK** of your **INSURANCE CARD** here.

Please tape a copy of the **BACK** of your **PRESCRIPTION CARD** here. (if different)

The Camp office must be notified if your child is exposed to any communicable disease during weeks prior to Camp attendance.

Parent's Authorization

It is our firm hope that the authorization below will never have to be used. In an emergency however, where immediate treatment is required before a parent can be contacted, this form can be extremely important. Without it, many doctors and hospitals will refuse to treat a minor as a matter of sound medical practice. Therefore, Camp requires this authorization to be signed by a parent for every camper and staff member.

In case of emergency, I hereby authorize the doctor or the hospital to which my child, may be brought, (and whomever they may designate as their assistants) to perform any emergency procedure or operation, to give treatment, injections, and the administration of an anesthetic to my child.

Signature of Parent _____ Print Name _____ Date _____

Last Name	First Name	Birth Date

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Camp Dina Medical Form — Physician's Page

Immunizations:

Immunization Type	Date Basic Series Completed	Most Recent Booster
DTaP / TDaP		
Tetanus		
MMR		
IPV		
HIB		
PCV		
Hepatitis B		
Hepatitis A		
Varicella		
Meningococcal		
H1N1		
Flu Shot		

If any of the immunizations above have not been received, please explain why:

Physical Exam:

Height	Weight	Pulse	Blood Pressure	Hct/Hgb. Test	Urinalysis
5'10"	180				

Eyes		Lungs	
Glasses		Abdomen	
Ears		Genitalia	
Nose		Hernia	
Throat		Extremities	
Heart		Posture (Spine)	
Neuro		Skin	

General Appraisal:	Medications:
Allergies:	Recommendations:

I have examined the above patient. Date Examined: _____ _____ In my opinion her condition ☐ **does** / ☐ **does not** allow participation in an active camp program.

Exceptions: _____

Physician's Name: _____ **Physician's Signature:** _____ **Date:** _____ **Phone #:** (____) _____—_____