CAMP 2025- MEDICAL FORM PART 2

TO BE FILLED OUT BY THE HEALTH CARE PROVIDER

Email completed forms to heathcenter@rollingriver.com or drop off at the Camp Office

CHILD'S NAME_____**DATE OF BIRTH**_____

Immunization History

Please record the date (month and year) of basic immunizations and most recent booster given.

Vaccines	Year of Basic Immunization	Year of Last Booster
DTaP		
TOPV/IPV		
Hib		
Hepatitis B		
Pneumococcal		
Varivax		
Measles		
Mumps		
Rubella		

Date of Last Tetanus Shot_____ ***Date of Last Covid Shot***_____

*****I attest that all immunizations required for school and camp are up to date.***

Health Care Recommendations

I have examined the above camp applicant within the past year. **Date examined** _____

In my opinion, the child's condition _____does OR _____does not preclude his/her participation in an active camp program.

Height _____ Weight _____ Blood Pressure _____Tb Testing results_____ Date _____

The applicant is under the care of a physician for the following condition(s):

_____

Current treatment (*includecurrent medications both RX and OTC)* _____

_____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Does the camper have epilepsy? _____ Does the camper have diabetes? _____

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp _____

_____

Any prescribed medication to be dispensed at camp *(specific dosages)* _____

_____

Any medically prescribed meal plan or dietary restrictions _____

_____

Any allergies (*food, drugs, plants, insects, etc.)* _____

_____

Activities to be encouraged, limited or excluded _____

_____

Description of any current physical, mental, or psychological condition requiring medication, treatment or special restrictions or conditions while at camp _____

_____

Additional Health Information (use back page if necessary:

_____

On the basis of my findings as indicated above and on my knowledge of the above named child, I find that:

- Child is free from contagious and communicable disease __ yes ___ no
  If no, please explain:_____
- Child is able to participate in an active camp program ___ yes ___ no

Licensed Physician's Signature_____**Date** _____

Address_____**Phone**_____

Date Form Completion_____**By**_____