2022 CAMP NAGEELA WEST MEDICAL FORM FOR DOCTORS

Camper's Full Name _____ Program Name_____ Camper DOB (mm/dd/yyyy): _____ ☒ **M** ☒ **F**

I understand this form will be viewed by the appropriate camp and medical staff and may be shared on a "need to know" basis with other camp staff. I give permission to photocopy this form. In addition, Camp Nageela has permission to obta in a copy of my child's health record from providers who treat my child and these providers may talk with the program staff about my child's health status.

Custodial Parent/Guardian Name _____ Custodial Parent/Guardian Signature _____Date _____

Custodial Parent/Guardian Phone Number: (____)_____

MEDICAL PERSONNEL: Please complete all of the information below. Attach additional sheets as needed.

Date of physical exam (mm/dd/yyyy)*:_____ (*The exam must be performed after September 2016, or during the last 6 months if child has endured serious illness.)

EXAMINATION

Height ____ft.___ in. Weight ____ lbs. Blood Pressure____ / _____ Blood Type _____ Glasses/contacts _____

Does this child have physical limitations that would prevent or limit him/her from taking part in any daily or adventure activities, such as hiking, swimming, backpacking, or ropes course ? ☒ **Yes** ☒ **No**

If yes, please explain: _____

Is this child currently taking any medication? ☒ **Yes** ☒ **No**

*Medication Name*_____ *Frequency*_____ *Dosage*____ Will treatment continue while at camp? ☒ **Yes** ☒ **No**

For what condition does s/he take this medication?_____

Comments or instructions regarding the taking of this medicine while at camp:_____

*Medication Name*_____ *Frequency*_____ *Dosage*____ Will treatment continue while at camp? ☒ **Yes** ☒ **No**

For what condition does s/he take this medication?_____

Comments or instructions regarding the taking of this medicine while at camp:_____

Please indicate any additional medications on a separate sheet.

Does this child have any allergies, including food, environmental, or medical allergies? ☒ **Yes** ☒ **No**

If yes, please explain allergy, reaction, and effective treatments: _____

Is this child undergoing treatment at this time for any existing conditions? ☒ **Yes** ☒ **No**

If yes, please explain: _____

Does the child have any current physical, mental, or psychological conditions, or other treatments or therapies requiring medication, treatment, or special restrictions or considerations while at camp? ☒ **Yes** ☒ **No**

If yes, please explain: _____

IMMUNIZATION HISTORY*

*Required immunizations must be determined locally. Please record the month/year of basic immunizations and most recent booster. Attach additional sheets as needed.

VACCINES	Date of Basic Immunization	Date of Last Booster
DPT (Diphtheria, Pertussis, Tetanus)		
TD or Tetanus		
Oral Polio (Sabin) TOPV		
Injectible Polio (Salk)		
Measles (hard measles, red measles)		
Mumps		
Rubella		
MMR booster after age 5		
Hepatitis B		
Date of most recent PPD or TB screening		
Other		

I have examined the person described herein and have reviewed his/her health history. I have discussed the camper program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in camp activities, except as noted above.

_____

Physician's Name (PRINT) Signature Title Date

_____ (____)

Address City State/Zip Code Phone