

# HEALTH STATEMENT

Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Family Health Insurance \_\_\_\_\_ ID # \_\_\_\_\_

This child is planning to attend a residential camp away from his/her home and more than 15 minutes from medical care. The camp has a Camp Healthcare Supervisor (Camp Nurse) who is a licensed registered nurse. Your response to these questions will help in the care of the child.

Past history of serious injuries or illnesses: \_\_\_\_\_

Any known drug reactions and/or allergies: \_\_\_\_\_

Any special dietary requirements: \_\_\_\_\_

List any prescription or nonprescription medication that the individual is taking. The Camp Health Supervisor will be responsible to administer all medications. Medications must be sent in original containers with directions for use.

<u>Name of Medication</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Over-the-counter medications such as Tylenol for fever and/or pain, Robitussin for cough or colds, Benadryl for allergy symptoms, and Pepto-Bismol for upset stomach will be available at the first aid office. If needed, these medications will be administered in the appropriate dosages for height and weight with the permission of the parent except as follows:

\_\_\_\_\_

## IMMUNIZATION RECORD:

Please complete month and year of most recent immunization for the following:

Tetanus/Diphtheria/Pertussis (DPT)DT Booster \_\_\_\_/\_\_\_\_ Oral Polio \_\_\_\_/\_\_\_\_

Measles/Mumps/Rubella (MMR) \_\_\_\_/\_\_\_\_ Other \_\_\_\_\_

## STATEMENT OF EXAMINATION:

I have examined this individual and found him/her to be in satisfactory physical condition and capable of active participation in a regular camp program except as follows:

\_\_\_\_\_

Signature of Physician or Nurse Practitioner \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name \_\_\_\_\_ Office Phone \_\_\_\_\_)

Address \_\_\_\_\_