

Health Care Recommendation by Licensed Physician

I have examined the above camp applicant. Date examined _____
In my opinion, the conditions listed above _____ do _____ do not preclude his/her participation in an active camp program.

Restrictions (if any) _____

Allergies (if any) _____

Other information _____

Height _____ Weight _____ Blood Pressure _____

Applicant is under care of a physician for the following condition(s) _____

Medication information form completed _____ yes _____ not applicable

THIS MUST BE COMPLETED IN ITS ENTIRETY FOR ATTENDANCE

Licensed Physician's Signature _____

Date of Form Completion _____ By* _____

**Initial if completed by nurse of physician's assistant*

IMPORTANT -- THIS BOX MUST BE COMPLETED FOR ATTENDANCE

The health history is correct so far as I know, and the person herein described as permission to engage in all camp activities except as noted.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment and to release any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above. This completed form may be photocopied for trips out of camp.

Parent (or Staff 18 and above) _____ Date _____

2012 CAMP BEN FRANKEL Immunization Form

Child's name _____ d/b _____

Parent / Guardian Signature _____

Date _____

May attach a photocopy