



Program Director
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Camp Office:
 PO Box 394
 Westbrookville, NY 12785
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 (Please call before faxing)

Empowering Youth to Serve Christ in the City

Camper Physician Form

To be completed by a licensed physician and returned to the camp office

Last Name _____ First Name _____ Sex _____ Birth Date _____

Height _____ Weight _____ B/P _____ Vision _____

Immunizations

New York State Law requires that immunization information with dates of most recent inoculations be provided prior to a camper's admission to camp.

DPT or DT _____ / _____ Polio _____ / _____ MMR _____ / _____ Hepatitis B _____ / _____ Tetanus _____ / _____

Allergies

Food Allergies: _____ Insect Allergies: _____

Other (penicillin, hay fever...): _____

Special Dietary Restrictions _____

Activity Restrictions (if any) _____

Significant Physical Findings _____

Presently under care for following condition(s) _____

Current Medications (All medications must be in original containers with the Pharmacy label attached)

Medication #1 _____ Dosage _____ Specific time taken each day _____

Reason for taking _____

Medication #2 _____ Dosage _____ Specific time taken each day _____

Reason for taking _____

Medication #3 _____ Dosage _____ Specific time taken each day _____

Reason for taking _____

Further information, restrictions or cautions _____

I have examined the patient herein described and have reviewed the health history. It is my opinion that this child is physically able to engage in regular camp activities, except as noted.

Physician's Signature _____ Date _____

Please Print Name _____ Phone _____