DOB:

HEIGHT:

AGE:

WEIGHT:

HEALTH RECORDS & INFORMATION – Please complete all information and/or attach your physician's form

BLOOD PRESSURE:

SKATER'S NAME:

GENDER: Male

Female

Insect: Is the person currently under the care of a physician? Circle: Yes No If yes, why?	DIAGNOSIS (AT PARENTS' DISCRETION):							
DPT (Diphtheria, Pertussis, Tetanus) TO (Tetanus, Diphtheria) Tetanus Polio MMR (Measles, Mumps, Rubella) Hepatitis B Varicella (Chicken Pox) Hib (Haemophilus influenza) Tuberculin Test Results Lead Test Results Lead Test Results Lead Test Results Unter HEALTH STATUS - Check if normal or give details Eyes Ears Lungs Genitalia Vision Hearing Posture Menstruation Skin Teeth Musc/Skel Herriia Throat Heart CNS Abdomen KNOWN ALLERGIES AND TREATMENT FOOD: MEDICATION: ENVIRONMENT: INSECT: Is the person currently under the care of a physician? Circle: Yes No If yes, why? Current medications or treatment: Recommend/Describe any limitations or restrictions on camp activities: Medications to be taken/administered at camp: (Including sunscreen, Inhalers, or the like) Name of Medication(s) MEDICATION POLICY - Please list ALL prescription medication, and any OTC or nonprescription drugs, taken routinely A sufficient supply of medication (enough to last the entire enrollment at camp) must be brought to the nurse. Please remember to keep the medication in the original, packaged container that identifies the prescribing physician (if a prescription drug), the name of the medication the dosage, and the frequency of administration. A Medical Authorization Form must be signed by the parent. Additional health information: Il have examined this child herein described and it is my opinion that this child is able to engage in and participate in all camp activities, unless otherwise noted above. (Date of examination must be within 24 months of start date of camp.) DATE OF EXAMINATION:	IMMUNIZATION HISTORY-	Please reco	rd the date (month	and year) of basio	c immunizations ar	nd most recent bo	oster doses	
TD (Tetanus, Diphtheria) Tetanus Polio MMR (Measles, Mumps, Rubella) Hepatitis B Varicella (Chicken Pox) Hib (Haemophilus influenza) Tuberculin Test Results Lead Test Results Cother HEALTH STATUS – Check if normal or give details Eyes Eyes Ears Lungs Genitalia Vision Hearing Posture Menstruation Skin Teeth Musc/Skel Hernia Throat Heart CNS Abdomen KNOWN ALLERGIES AND TREATMENT FOOD: MEDICATION: INSECT: Is the person currently under the care of a physician? Circle: Yes No If yes, why? Current medications or treatment: Recommend/Describe any limitations or restrictions on camp activities: Medications to be taken/administered at camp: (including sunscreen, inhalers, or the like) Name of Medication(s) MEDICATION POLICY - Please list ALL prescription medication, and any OTC or nonprescription drugs, taken routinely A sufficient supply of medication (enough to last the entire enrollment at camp) must be brought to the nurse. Please remember to keep the medication in the original, packaged container that identifies the prescribing physician (if a prescription drug), the name of the medication hadditional health information: MEDICATION POLICY - Please list ALL prescription medication, and any OTC or nonprescription drugs, taken routinely A sufficient supply of medication (enough to last the entire enrollment at camp) must be brought to the nurse. Please remember to keep the medication in the original, packaged container that identifies the prescribing physician (if a prescription drug), the name of the medication in the dosage, and the frequency of administration. A Medical Authorization Form must be signed by the parent. Additional health information: Li have examined this child herein described and it is my opinion that this child is able to engage in and participate in all camp activities, unless otherwise noted above. (Date of examination must be within 24 months of start date of	Vaccines		Month/Year	Month/Year	Month/Year	Month/Year	Month/Year	
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