

# Physician's Report

## Summer of 2010



P.O. Box 1143  
Ridgewood, NJ 07451  
201.251.0414  
Fax 201.652.7002

The camper's physician must complete both sides of this form and the accompanying Standing Orders sheet. Please return to the camp office by June 1. All information will be held in the strictest confidence; please be as thorough as possible.

Child's name ..... Date of Birth .....

Date ..... Weight ..... Height .....

Blood Pressure ..... Urine ..... Hematocrit .....

### Health Care Recommendations by Licensed Physician

I have examined the child within the past year. Date examined .....

The NY Department of Health requires that a physical exam was completed no more than a year prior to the last day of camp, August 16.

Is the camper able to participate in an active camp program?  Yes  No

Camper is under the care of a physician for the following condition(s): .....

Current treatment (include current medications): .....

Explanation of any reported loss of consciousness, convulsion, or concussion: .....

### Are there any...

Allergies (food, drugs, plants, insects, etc.)? .....

If yes, should exposure occur, how should the allergic reaction be treated? If this is an anaphylactic response, will this child's parents supply an epinephrine device?

Cardiovascular conditions? .....

Respiratory conditions? .....

Middle ear conditions? .....

Gastrointestinal conditions? .....

**Please complete both sides of this form.**

Office Use Only. Please do not place any marks inside this box.

**Are there any...**

Neurological conditions? .....

Orthopedic conditions? .....

Activity restrictions? .....

Special diet? .....

Treatment(s) to be continued at camp? .....

Medication(s) to be administered at camp? .....

    Same as during the school year? .....

Additional medical or psychological conditions not listed which we should be aware of? .....

**Camper Immunization History**

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
DPT Series, Diphtheria, Pertussis, Tetanus <b>OR</b>	1 2 3	1 2 3
TD Series, Tetanus, Diphtheria <b>OR</b>		
Tetanus		
Polio Series		
MMR Series		
HIB Series		
Hepatitis B Series		
Chicken Pox (illness or vaccine)		
Meningitis		
Other		

*We may have neglected to ask something you feel is needed to adequately address the health needs of this child. If that is the case, please add your comments. Thank you for helping us to provide a successful summer experience for this camper!*

**Licensed Physician's Signature**.....

Physician's Printed Name.....

Physician's Address ..... Phone.....  
Street City, State, Zip Area Code/Number

Date of Form Completion ..... \*By .....  
\*Initial if completed by nurse or physician's assistant.