# Summer Camps at College Settlement 2018 CIT Medical Form 2

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## To be filled out by Licensed Physician



Session will attend Camp: _____

Child Name: _____ ☐ Male ☐ Female Birth date: _____

Child's Address:_____

Physical exam done today: ☐ Yes ☐ No (if "no" date of last Physical: _____

*ACA accreditation standards specify physical exam within last 12 months.*

Weight: _____lbs Height: _____ft_____in Blood Pressure: _____/_____

Allergies: ☐ No known Allergies

☐ Food (list):_____

☐ To Medications: (list):_____

☐ To the environment (list):_____

☐ Other allergies: (list):_____

Please describe reactions:

_____

_____

_____

**Diet, Nutrition:** ☐ Eats a regular diet ☐ Has a medically prescribed meal plan or dietary restrictions: (describe below)

_____

_____

**The child is undergoing treatment at this time for the following conditions:** (describe below)

_____

_____

**Medication:** ☐ No daily medications ☐ Will take the following prescribed medication(s) while at Camp: (name, dose, frequency)

_____

_____

**Other treatment/therapies to be continued at Camp:** (describe below) ☐ None needed.

_____

_____

**Do you feel that the child will require limitations or restrictions to activities while at Camp?** ☐ Yes ☐ No (if yes, what do you recommend)

_____

_____

"I have discussed the Camp program with the child's parent/guardian. It is my opinion that the camper is physically and emotionally fit to participate in an active Camp program (except as noted above)"

Name of licensed provider (print):_____ Signature: _____ Title: _____

Office Address: _____ Phone #:_____

Date: _____

*SEE REVERSE FOR IMMUNIZATION HISTORY*

*TO BE SUBMITTED AT LEAST 4 WEEKS PRIOR TO CHILD'S EMPLOYMENT*

Camper Last Name:---------- Camper First Name ---------- (for camp use) Unit:---------- (for camp use) Session:----------

**Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must be current.**
**Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.**

| Immunization | Most Recent Dose Month/Year | Immunization | Most Recent Dose Month/Year |
|---|---|---|---|
| Diptheria, tetanus, pertussis (DTaP) or (TdaP) | | Tetanus booster (dT) or (TdaP) | |
| Mumps, measles, rubella (MMR) | | Polio (IPV) | |
| Haemophilus influenzae type B (HIB) | | Pneumococcal (PCV) | |
| Hepatitis B | | Hepatitis A | |
| Varicella (chicken pox) ☐ Had chicken pox Date: | | Meningococcal meningitis (MCV4) | |
| Tuberculosis (TB) test: | Date: | ☐ Negative ☐ Positive | |

If your camper has NOT been fully immunized, please sign the following statement. I understand and accept the risks to my child from not being fully immunized.

❖ Parent/Guardian _____Date:_____