

Summer at Wooster Health Form

This form must be completed and signed by a physician before your child can attend camp. A new physical exam is not required provided the exam has been completed within the past two years.

Camper Staff

Name Date of Birth

Phone (.....) Guardian

Street City State Zip Code

Mother's name Phone (.....)

Father's name Phone (.....)

Emergency contact Phone (.....)

Mother's cell phone (.....) Father's cell phone (.....)

Administration of over-the-counter medications

We will not administer medications except over-the-counter topical medications such as antibiotic ointments and anti-itch creams.

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

Date of Examination

May participate in all camp activities

May participate in all camp activities except for

Medical information pertinent to routine care and emergencies

Is this individual taking prescription medication? YES NO

If yes, indicate prescription

Will this individual carry an inhaler during camp? YES NO

If yes, indicate prescription

Does the individual have allergies? YES NO

If yes, explain

Is this individual on a special diet? YES NO

If yes, explain

This camper/staff is up to date on all of the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

| | | |
|-------------|------------------------------|-----------------------------|
| Measles | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hepatitis B | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Mumps | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diphtheria | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Rubella | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

| | | |
|-------------|------------------------------|-----------------------------|
| Pertussis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Chicken Pox | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Polio | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Tetanus | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Other health concerns

Name of medical care provider (Please print)

Medical care provider's address

Medical care provider's phone (.....)

Signature of Physician, APRN, or PA

Date form was signed