

**Camper Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_ **Age at Camp** \_\_\_\_\_

*first middle last*

[illegible]

## PHYSICIAN'S RECCOMENDATIONS & RESTRICTIONS

I examined \_\_\_\_\_ on \_\_\_\_\_  
*camper's full name* *DOB* *date of most recent examination*

Weight(kg) \_\_\_\_\_ Height(cm) \_\_\_\_\_ BP \_\_\_\_\_

Allergies: \_\_\_\_\_

Last blood count : Date \_\_\_\_\_ Hgb \_\_\_\_\_ Hct \_\_\_\_\_ WBC \_\_\_\_\_ Platelets \_\_\_\_\_

Differential or ANC \_\_\_\_\_ Varicella Titer \_\_\_\_\_

Date of last Tetanus shot (**required**) \_\_\_\_\_ Colonization of VRE: (circle one) **yes** **no**

### Current physical and medical condition:

\_\_\_\_\_  
\_\_\_\_\_

### Current chemotherapy. Please include a copy of current chemotherapy roadmap or regimen.

Physician should write an order describing the dose and method of administration (including chemotherapy, TPN, antibiotics or other infusions). It is necessary for the camper's parent & healthcare team to arrange the transport of these medications to camp.

\_\_\_\_\_  
\_\_\_\_\_

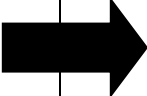
### Any medically-prescribed meal plan or dietary restrictions:

\_\_\_\_\_

### Description of any limitation, concern or restriction on camp activities:

\_\_\_\_\_  
\_\_\_\_\_

***I hereby verify that the information on the above form and preceding forms concerning health matters and medications is correct. In my opinion, this child is able to participate in Camp Sunshine's Summer Camp and Year Round Programs.***

 **Signature of Physician/Practitioner** \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Phone: \_\_\_\_\_

### FOR CAMP SUNSHINE MEDICAL STAFF SCREENING USE ONLY

FORM REVIEWED BY: \_\_\_\_\_

DATE: \_\_\_\_\_

UPDATES TO HEALTH HISTORY NOTED: YES NO NONE

ADDITIONAL COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MEDICATIONS RECEIVED:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_