

Summer Programs at the Kate!

Medical Form - Required of all participants

PLEASE NOTE: Your child's **blue physical form** is sufficient, current within the last 3 years. Please return to: **The Kate, 300 Main Street, Old Saybrook, CT 06475** or email **Robin.Menzies@thekate.org**

Due ASAP but no later than two weeks of the first day of session.

Child's Name _____ DOB _____
 Parent/Guardian _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Cell _____ Work _____
 Medical Insurance Carrier _____ ID # _____
 Named of Insured _____

SECTION BELOW TO BE COMPLETED BY MEDICAL PRATITIONER:

May participate in all camp activities

Date of Exam ___ / ___ / ___

May participate except for _____

Medical information pertinent to routine care and emergencies: _____

Is this individual using an EpiPen or inhaler or taking prescription or over the counter medication(s)? YES NO

If yes, indicate names of medication(s): _____

Will the individual need the medication(s) during camp hours? YES NO
 (If YES, please submit a **Medication Authorization Form**)

Does the individual have allergies? YES NO Explain: _____

Is the individual on a special diet? YES NO Explain: _____

Does the individual have special needs? YES NO Explain: _____

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

	YES	NO		YES	NO
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis	<input type="checkbox"/>	<input type="checkbox"/>
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal Conjugate	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town _____ State _____ Zip _____

Telephone Number: _____

Signature of Physician, PA, APRN or RN _____ Date _____

FOR OFFICE USE:
 S1 S2 S3
 S4 S5 SP