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	☐	☐	Hepatitis B	☐	☐
Mumps	☐	☐	Diptheria	☐	☐
Rubella	☐	☐	Pertussis	☐	☐
Chickenpox	☐	☐	Pneumococcal Conjugate	☐	☐
Tetanus	☐	☐	Polio	☐	☐

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