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**

Please submit ASAP and no later than May 1st.

Child's Name_____ DOB _____

Parent/Guardian_____

Address _____

City _____State_____ Zip _____

Home Phone_____ Cell_____ Work_____

Medical Insurance Carrier_____ ID #_____

Named of Insured _____

SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Exam ___/___/___

◯ May participate in all camp activities

◯ May participate except for

_____

Medical information pertinent to routine care and emergencies: _____

_____

Are there any prescription or over the counter medication(s) this individual needs to take while at camp, including EpiPen/inhaler?

◯ Yes ◯ No If yes, indicate names of medication(s): _____

NOTE: *A written authorization for the administration of medication at camp is required.*

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: _____

NOTE: *If the camper has a special health care need or disability that requires special care be taken or provided during camp, an individual plan of care shall be developed with the parent and health care provider.*

Is this individual immunized in accordance with the schedule adopted by the Commission of Public Health pursuant to section 19a-7F of the Connecticut General States? ◯ Yes ◯ No

Additional comments: _____

_____

Printed name of Health Care Provider _____

Address _____ Phone _____

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