Camper Name: _____ Date of Birth: ___/___/___
Last Middle First Day/Month/Year

CAMP SEQUOIA HEALTH FORM

Physician Information
(Page 1 of 2)

This form must be filled out and returned by

MAY 3rd

Camp Sequoia
3 Ainsley Court
Newtown, PA 18940
Fax: 1-610-771-0122
(Please keep a copy for your records as well.)

Camper Name _____ (For Camp Use) Cabin or Group _____ (For Camp Use) Session Code(s):

***Medical Personnel:** Please review the CAMPER SEQUOIA HEALTH FORM (parent information) and complete all remaining sections of this form (page 2). Attach additional information if needed.*

Physical exam done today: ☐ Yes ☐ No **(If "No," date of last physical:** _____) Month/Day/Year

ACA accreditation standards specify physical exam within last 24 months.

Weight: _____ lbs Height: _____ ft _____ in Blood Pressure _____ / _____

Allergies (Please describe known reactions) ☐ No Known Allergies

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions: ***(describe below).*** *Eats a vegetarian diet*

The camper is undergoing treatment at this time for the following conditions: *(describe below)* ☐ None.

Other treatments/therapies to be continued at camp: *(describe below)* ☐ None needed.

Camper Name: _____ Date of Birth: ___/___/___
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CAMP SEQUOIA
HEALTH FORM
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IMMUNIZATION RECORD

Please provide the month and year for each immunization below. Copies of these records from health-care providers or local governments are acceptable. Please attach copies to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis☐ (DTaP) or (TdaP)						
Tetanus booster☐ (dT) or (TdaP)						
Mumps, measles, rubella☐ (MMR)						
Polio☐ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) †Had chicken pox Date:						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) test	Date:	☐ Negative		☐ Positive		

If your camper has not been fully immunized, please sign the following statement: **I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. *Cross out those the camper **should not** be given.*

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes
If you answered "Yes" to the question above, what do you recommend? ***(describe below—attach additional information if needed)***

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address _____
Street City State Zip

Telephone: (_____) Date: _____