



CAMP SEQUOIA
HEALTH FORM
Physician's
Information

Camper Name: _____
LAST FIRST MIDDLE

Birthday: ____/____/____
MM/DD/YYYY

This form must be filled out and returned by:
May 1st
Camp Sequoia
3 Ainsley Ct. Newtown, PA 18940
Fax: 610-771-0122
Email: info@camp-sequoia.com
This form can also be uploaded to the parent portal on our website
Please keep a copy for your records as well

MEDICAL PERSONNEL: Please review and complete this form. Attach additional information if needed.

Physical done today?: Yes No (If "No," date of last physical: _____) *Physical exam must be within
Month/Day/Year the last 24 months.

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

Allergies (Please describe known reactions): No Known Allergies

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

Camper is currently undergoing treatment for the following conditions (describe below): None

Medical Professionals: The following non-prescription medications may be stocked in the camp Health Center and are used on a PRN basis to manage illness and injury. Cross out those the camper should not be given.

- Acetaminophen (Tylenol)
- Calamine lotion
- Ibuprofen (Advil, Motrin)
- Bismuth subsalicylate (Pepto-Bismol)
- Phenylephrine (Sudafed PE)
- Laxatives for constipation (Ex-Lax)
- Pseudoephedrine (Sudafed)
- Hydrocortisone 1% cream
- Chlorpheniramine maleate
- Topical antibiotic cream
- Guaifenesin
- Dextromethorphan
- Aloe
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo
- Melatonin (<5mg)

Other treatments/therapies to be continued at camp: (describe below—
attach additional information if needed): None needed

Does the camper require limitations or restrictions to activity while at camp? No Yes

If you answered "Yes" to the question above, please specify? (attach additional information if needed)

Has the camper received their required immunizations? Yes* No **NO: If your camper has not been fully immunized, please have parent sign the following statement: I understand and accept the risks to my child from not being fully immunized**

Parent/Custodial Guardian Signature: _____ Date: _____

Physician: Please attach immunization records to this document

"I have reviewed this form 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 _____ Phone: _____