

Stone Mountain Adventures Physicians Report

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HEALTH CARE RECOMMENDATIONS BY A LICENSED PHYSICIAN

I examined (NAME) _____ this individual on

(DATE) _____. BP _____ Weight _____ Height _____

in my professional opinion, the individual named **is / is not** able to participate in an active camp program.

The individual is under the care of a physician for the following conditions:

RECOMMENDATIONS AND RESTRICTIONS AT CAMP

Treatment to be continued at camp

Medications to be administered at camp (name, dosage, frequency)

Any medically-prescribed meal plan or dietary restrictions

Known Allergies

Description of any limitation or restriction on camp activities

Additional information for health care staff at camp

IMPORTANT: Use the following space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

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Please check which of the following the participant has had in the past :

___ Measles ___ Chicken Pox ___ German measles ___ Mumps ___ Hepatitis A

___ Hepatitis B ___ Hepatitis C

TB Mantoux Test: Date of last test _____ Result (circle one): Positive Negative

DATES OF IMMUNIZATION

Vaccine:	Dates:
DTP	_____
TD(tetanus/diphtheria)	_____
Tetanus	_____
Polio	_____
MMR	_____
Or Measles	_____
Or Mumps	_____
Or Rubella	_____
Haemophilus influenza B	_____
Hepatitis B	_____
Varicella (chicken pox)	_____

Signature of Licensed Physician _____

Printed _____

Address _____ Town/City _____

State _____ Zip _____

Phone _____