AICL Healthcare Provider Form

Updated 5.3.09

Camper Name:____
Parent/Guardian Name:____
Parent Phone(s):____
Additional Emergency Contact Name & Phone:______________________________
____

Physicians: Please completely fill out this form (you may attach a copy of your own form, but please fill in any missing information.)
*Please sign this form even if you attach your own form

Allergies
Allergy to medication or foods:_______________________________________
Reaction:____
Treatment needed:____
Allergy to plant or animal or insect toxin:_______________________________
Reaction:____
Treatment needed:____
Does camper have a history of allergies other than those listed above?
____
____

Immunizations:
D.T.P. (5 doses) ______ _______ _______ _______ ______
MMR (2 doses) ______ ______
Polio (4 doses) ______ _______ _______ _______
Hep b (3 doses if born after 1/1/92) ______ _______ _______
Varivax ______ (or month and year of disease _______)
TD booster (within 10 years) _________
Hib _______ _______ _______ _______

Examination findings:
Ht. ______ Wt. _______ B/P _______ Pulse _______
Vision: Normal _____ Glasses _____ Contacts _____
Hearing: Normal _____ Abnormal _____ Hearing Aides _____
Physical Findings:
____
____
____
Please note any abnormal physical findings and specify any physical or dietary limitations:____
____
____
____
____

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Approved for participation in: All activities ______ Hiking and camping _____ Water activities ______ Competitive sports ______
Restrictions ____

Medications needed at camp?
Yes ____ No ____
Name/Dosage Instructions:
____
____
____
____
____
____
____

Physician Signature:_________________________________ M.D/D.O./P.A./NP

Date ________________ Office Phone # (____) ____________________

Parents: Do you give camp staff permission to administer over-the-counter medications in appropriate dosage amounts if necessary? Yes _____ No ______

Parent Signature:____