MEDICAL FORM

RETURN TO CAMP by May 1st, 2007

[To be SIGNED BY PHYSICIAN,completed front and back by parents of minors and by adult staff members]

Last Name ____________________ First ____________________

Sex______ Date of Birth____________ Age_______ Session____________________ Cabin____________________
(office use)

Responsible Party Name________________________ Home Phone ________________________

Address ________________________ Cell Phone ________________________

Day Phone Mother________________________ Day Phone Father ________________________

Physician: ________________________ Telephone ________________________

Dentist: ________________________ Telephone ________________________

Orthodontist: ________________________ Telephone ________________________

Name and phone number of at least three persons whom we may contact in case of emergency.

Name:____________________ Relationship:____________________ Tel:__________

Name:____________________ Relationship:____________________ Tel:__________

Name:____________________ Relationship:____________________ Tel:__________

Dietary restrictions? ____

Allergies?____

** Please be aware that we use peanut products at Adirondack Camp**

Medical insurance (Include a front and back copy of your insurance card. Indicate if they must be contacted prior to treatment)

Carrier____________________ Policy or Group #____________________Phone ____________________

Please note any other facts relating to your child's health, which you feel could be important or helpful to the camp (menstruation, contagious diseases, serious injuries, operations, allergies etc.).

____

____

(Please read the paragraph below and sign before returning to camp)

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests and treatment for me/or my child. And in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and /or anesthesia and or surgery for me/or my child as named above. This form may be photocopied for the use out of camp.

____ ____________________

Parent's Signature (or staff signature) Date

PHYSICAL REQUIREMENTS

(OVER)

All campers and staff must have a physical examination dated within one year. Part II (below) must be completed and signed by your physician. This form must be on file with the Camp prior to the first day of June. **Failure to comply with the above requirements may prevent you/ your child from participating in camp activities.**

Part II. TO BE COMPLETED BY PHYSICIAN

Please fill in all spaces, either with dates or "not immunized"

Date of Initial Immunization (Month/Day/Year) Date of Booster Doses

DPT/DT 1.___/___/___ 2.___/___/___ 3.___/___/___ 1.___/___/___ 2.___/___/___ 3.__/___/___

Polio 1.___/___/___ 2.___/___/___ 3.___/___/___ 1.___/___/___ 2.___/___/___ 3.__/___/___

Haemophilus Influenza type b ___/___/___ Hepatitis b ___/___/___ Varicella ___/___/___

Live Measles Vaccine ___/___/___ Mumps__/___/___ Rubella___/___/___ MMR___/___/___ Booster__/___/___

Tuberculin Test (last date only) ___/___/___ Result _______________

All International campers and staff must have a TB test within past year.

Please note history of any of the following diseases:

Diabetes-
Heart Disease, including Rheumatic Fever-
Neurological Disorders, including Epilepsy-
Chronic or serious illnesses-
Birth Defects or injury-
Operations-
Hearing Difficulty-
Speech Difficulty-

Height:___________ Weight:___________ Blood Pressure:________________

Any medication to be administered at camp. Please specify times and dosage.

Medication	Dose	Freq	Reason

PHYSICIAN SIGNATURE:

I have examined ____ on _______________________________

and find him/her in good general health and able to participate in all camp activities without restriction.**

**(Activities may include but are not restricted to Archery, Athletics, , Canoeing, Creative Arts, Culinary Arts, Drama, Fencing, Fishing, Golf, Hiking, Kayaking, Rock-climbing, Sailing, Snorkeling, Soccer, Swimming, Waterskiing, Windsurfing)

____ ____

Pysicians Name

Physicans Signature

Phone ____________________________________

Address ____

____

____

Date of completion_____________________

Completed by_________________________