

CAMP KAWANHEE — PHYSICIAN'S REPORT

Date of Exam _____

Name _____ Birth Date _____ Age at Camp _____

Home Address _____
Last First Middle Street Address City State Zip

Weight _____ Height _____ BP _____

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____				
or Measles		_____	_____				
or Mumps		_____	_____				
or Rubella		_____	_____				
Hepatitis B		_____	_____	_____			
Varicella		_____	_____				

Significant Past Medical History/Restrictions: _____

Medical Allergies: _____

Other Allergies: _____

Medications Being Taken:

Please list ALL medication (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person **takes NO medication** on a routine basis

-OR-

This person **takes medication** as follows

Med#1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med#2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medication

Identify any medication taken during the school year that participant does/may not take during the summer:

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date _____