# Camp Health Form - 2016

**2016 Camp Dudley/Kiniya HEALTH CARE PROVIDER RECOMMENDATION FORM**
**All information must be to Camp Office by May 1, 2016**

Camper: _____ Camp Number: _____ DOB: _____ Gender: _____

Parent/Guardian (w/ whom child resides): _____

**Physical must be within the 12 months prior to arrival at Camp for everyone camper through staff.**

**To Be Completed in Full by Health Care Provider**

Height _____ft. _____in. Weight _____lbs. Blood Pressure _____/_____ Pulse _____ Contacts lenses Y N

Allergies _____

_____

| | | | | | |
|---|---|---|---|---|---|
| Eyes | _____ | Skin | _____ | Abdomen | _____ |
| Ears | _____ | Heart | _____ | Genitalia | _____ |
| Nose | _____ | Lungs | _____ | Hernia | _____ |
| Throat | _____ | Spine | _____ | Extremities | _____ |

General appraisal, recommendations and restrictions (diet, medicine, swimming, etc.):

_____

_____

_____

_____

☐ No Daily Meds or ☐ Will take prescribed medication while at Camp
(Must complete Authorization for Administration of Medicine)

☐ Immunizations for this camper are up-to-date. Date of most recent Tetanus booster _____
Month and Year

Measles Vaccinations (MMR or MMRV) 1st dose: (date) ____ 2nd Dose: (date) _____

I found the applicant's physical condition warrants admission to summer camp and his/her participation in all activities, except as noted.

Health care provider's signature_____ Date _____

Health care provider's printed name_____
**Please note: Original health care provider's signature required.**

Address _____
City State/Country Zip/Postal Code

Phone _____

**Please attach a copy of the current immunization record to this form.**