

CAMPER MEDICAL FORM

*(To be completed and signed by **Specialist**)*

Camper's Name: _____ DOB: _____ Date of Diagnosis: _____

Primary Diagnosis: _____

Other Diagnoses: _____

Mental Health Diagnoses (including any recent hospitalizations for mental health): _____

Has the Camper been diagnosed with Autism? Yes No

Allergies: _____

Please describe all **current medical problems**: _____

******A copy of the most recent Office/Clinic Visit Notes must also be sent to Camp Boggy Creek******

MEDICATIONS

Name:	Dose:	Route:	Frequency:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is the child's development appropriate for his/her age? Yes No

If no, at what age does s/he function? _____

Pertinent Mental Health Information, including behavior problems that would affect child's participation in a group:

Please specify any camp activity restrictions: _____

Provider Statement: I have examined this child and find him/her physically/mentally able to attend camp.

I understand that the above Treatment Plan will be followed at camp, unless other orders are received.

Signature of Specialist **Print Specialist Name** **Date**

Treatment Center **Emergency number** **Fax number**

Specialist's email address



(Camp Boggy Creek fax 352-306-0674)