DiamondRidge
• C A M P S •

NOTE Camp Policy:
Your child may not begin camp season until this form is on file in Camp.

office use:

Physician Health Certification

Single Side Only - **To be Completed by Licensed Physician**. Return to camp by: MAY 1st

Camper Name ____ Birthdate ____________________

I. Camper Immunization History:

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses. Physician may attach copy of child's immunization records.

	Birth	1 Mo	2 Mos	4 Mos	6 Mos	12 Mos	15 Mos	18 Mos	4-6 Yrs
Hepatitis B									
Hib									
Polio									
DTaP									
Pneumococcal									
MMR									
Varicella									
Influenza									
Hepatitis A									

II. Health Care Recommendations by Licensed Physician (this portion must be completed to attend camp)

I have examined the above camp applicant within the past two years. **Date Examined** ________________

The patient was found to be in good health and may participate in an active camp program with the following exceptions.

Height ____________ Weight ______________ Blood Pressure ____________________________

The applicant is under the care of a physician for the following condition(s):

____

Current treatment (include current medications) ____

Explanation of any reported loss of consciousness, convulsion, or concussion ______________________

____

Is there a history of epilepsy? Yes ☐ No ☐ Is there a history of diabetes? ☐ Yes ☐ No

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp ____

Any medication to be administered at camp *(specific dosages)* ____________________________

Any medically prescribed meal plan or dietary restrictions _________________________________

Any allergies *(food, drugs, plants, insects, etc.)* ______________________________________

Activities to be encouraged or limited ____

Additional Health Information ____

Licensed Physician's Signature/Stamp____

Address____ Phone _______________________
Street & Number *City, State & Zip* *Area/Number*

Date of Form Completion ___________________ *By ______________________________________
** Initial if completed by nurse or physician's assistant.*

Return completed form to Diamond Ridge Camps • Box 297 • Jamison, PA 18929 • FAX: 215-343-8849