CAMP DAYBREAK

Camper Physician Form

Camper's Name _____ ☐ Male ☐ Female
First Middle Last

Birthdate _____ Height _____ Weight _____ BP _____
Month/Day/Year

Name of Physician: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

Email: _____

Please Indicate if Abnormal	Yes	No		Yes	No
1. Head……	☐	☐	8. Lungs……	☐	☐
2. Eyes……	☐	☐	9. Hearing……	☐	☐
3. Ears……	☐	☐	10. Heart……	☐	☐
4. Nose……	☐	☐	11. Abdomen……	☐	☐
5. Mouth……	☐	☐	12. Genitalia……	☐	☐
6. Neck……	☐	☐	13. Extremities……	☐	☐
7. Neurological……	☐	☐			

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

_____

_____

Does this person have physical, mental ,or medical challenges that would limit participation in a summer camp program? ☐ No ☐ Yes

*If you answered "yes" to the question above, please explain.

Certification:

I certify that: (please initial)

_____ this person may **not** participate in camping activities
_____ this person may participate in routine camping activities
_____ this person may participate in camping activities with restrictions (please list)

_____

_____ I have included an up to date **immunization** and **medication record.**

Signature of physician _____

Printed Name _____ Date _____

(For camp use only)
Name _____ First _____ Middle _____ Last _____ Family:_____ Cabin_____

* Completed forms can be sent to Camp Daybreak, 100 State St Suite 352, Montpelier, VT 05602