AVON OLD FARMS
SUMMER CAMPS

Camper Name: _____ Sex: _____

Date of Birth: _____ Age: _____

Physicians: Please complete all areas of this form below. ***Please attach a copy of the camper's immunization record.***

Date of Exam: _____

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____

Is the camper currently under the care of a physician for any condition(s)?
☐ Yes (Please provide details below) ☐ No

Is the camper currently taking any medications?
☐ Yes ☐ No

Will the camper need to take any of these medications while at camp?
☐ Yes (Please complete the appropriate forms for self-administration of medication) ☐ No

Does the camper have epilepsy?
☐ Yes ☐ No

Does the camper have asthma?
☐ Yes ☐ No

Does the camper have diabetes?
☐ Yes (Please provide a plan of care and appropriate testing equipment) ☐ No

Please explain in the space provided below any reported loss of consciousness, convulsion, or concussion

Does the camper need to follow a medically prescribed meal plan or does the camper have any dietary restrictions?
☐ Yes (Please provide details below) ☐ No

Does the camper have any allergies?
☐ Yes (Please provide details below) ☐ No

This camper *(please check the appropriate box below)*

☐ may participate in **all** camp activities

☐ may participate in **some** camp activities
(please provide details below)

☐ ***may not*** participate in any camp activities

Physician Name – Please Print

Street Address City State Zip Code

Physician Signature Date