Stone Mountain Adventures Physicians Report

9803 Old Hawn Rd., Huntingdon, PA 16652   814-667-3874
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HEATH CARE RECOMMENTATIONS BY A LICENSED PHYSICIAN

I examined (CAMPER NAME)____ on

(DATE)______________BP______________Weight___________Height ___________

in my professional opinion, the individual named **is / is not** able to participate in an active camp program.The individual is under the care of a physician for the following conditions:

____

____

RECOMMENDATIONS AND RESTRICTIONS AT CAMP

Treatment to be continued at camp

____

____

Medications to be administered at camp (name, dosage, frequency)

____

____

Any medically-prescribed meal plan or dietary restrictions

____

____

Known Allergies

____

____

Description of any limitation or restriction on camp activities

____

____

Additional information for health care staff at camp

____

IMPORTANT: Use the following space to provide any additional information about the participant'sbehavior and physical, emotional, or mental health about which the camp should be aware.

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Physician's Report- Page 2

Please check which of the following the participant has had in the past :

____ Measles___Chicken Pox____German measles___Mumps____Hepatitis A

____ Hepatitis B_____Hepatitis C

TB Mantoux Test: Date of last test_______________Result (circle one): Positive Negative

DATES OF IMMUNIZATION

Vaccine:	Dates:
DTP	____________________
TD(tetanus/diphtheria)	____________________
Tetanus	____________________
Polio	____________________
MMR	____________________
Or Measles	_______________
Or Mumps	_______________
Or Rubella	_______________
Haemophilus influenza B	____________________
Hepatitis B	____________________
Varicella (chicken pox)	____________________

Signature of Licensed Physician ______________________________

Printed ______________________________

Address______________________________Town/City____________________

State________Zip ______________

Phone ______________________________

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