# Stone Mountain Adventures Physicians Report

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## HEATH CARE RECOMMENTATIONS BY A LICENSED PHYSICIAN

I examined (NAME)_____this individual 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's behavior and physical, emotional, or mental health about which the camp should be aware.

_____

_____

_____

_____

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**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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