CAMPER MEDICAL FORM

(To be completed and signed by **Specialist**)

Camper's Name:		DOB:	Date of Diagnosis.:
Primary Diagnosis:			_
Other Diagnoses:			
Mental Health Diagnoses (inc	cluding any recent hospit	alizations for mental he	ealth):
			,
Has the Camper been diagnos	sed with Autism?	Yes O No	
Allergies:			
8			
i lease describe an editent in	edicai problems.		
****A copy of the most rec	ent Office/Clinic Visit	Notes must also be s	sent to Camp Boggy Creek****
••			
MEDICATIONS			
Name:	Dose:	Route:	Frequency:
	·		
	,		
	,		
Is the child's development ap	propriate for his/her age	$O_{\text{Vec}} O_{\text{No}}$	
•			
ii iio, at what age doc	es s/ ne function?		
Pertinent Mental Health Info	rmation including behav	vior problems that would	d affect child's participation in a group
1 Crunent Wentar Freatur IIIIO	imation, including behav	noi problems that woul	arrect clind's participation in a group.
Please specify any camp activ	ity restrictions:		
ricase specify any earnip activi	ity restrictions.		
		1 , ,	/mentally able to attend camp.
I understand that the above T	Freatment Plan will be fo	llowed at camp, unless	other orders are received.
C:		Constitut NI and	Dete
Signature of Specialist		Specialist Name	Date
Treatment Center			Fax number
		gency number	rax number
Specialist's email address			
		CAMP	

