CAMP OHR CHEDVAH

396 ADEN ROAD LIBERTY, NY 12754
TEL: 845.292.2101 FAX: 845.292.7986

MEDICAL EXAMINATION

Both sides to be filled in by Licensed Physician

The purpose of this health Information is to provide the camp with pertinent information to serve the needs of this child.

CHILD'S NAME: _____

VITAL STATISTICS AND INFORMATION

Height _____ Nose _____ Athlete's Foot?_____ Posture (spine) _____

Weight _____ Throat _____ Heart _____ Allergies? Please specify:

Eyes _____ Teeth _____ Lungs _____ _____

Glasses _____ Skin _____ Abdomen _____ Hair (free of nits) _____

Ears_____ Feet _____ Hernia _____ General Appearance:

_____

IMMUNIZATION RECORD VERY IMPORTANT - Please give dates of basic immunizations and most recent boosters

D-T-P_____ Polio Vaccine _____ Influenza _____

Hepatitis B _____ HIB _____ Pneumococcal _____

Meningococcal _____ HEP A _____ HPV _____

MMR _____ Varicella (chicken pox) _____ Meningitis _____

RESTRICTIONS

Are there any restrictions while in camp?

Swimming _____

Diet _____

Strenuous Activities _____

RECOMMENDATIONS AND OTHER PERTINENT INFORMATION

_____

_____

Is there any medicine needed? _____ Please specify: _____

If yes, is parent sending it along with child? _____ Very Important! Include a copy of the prescription.

PHYSICIAN

Physician Name _____

Address _____

City/State/Zip _____

Phone _____ Summer Phone Number (if applicable) _____

Physician's Signature _____ MD