Please return to: Summer Roundup
PO Box 355
Bozman, MD 21612

amyschisler@me.com

Staff Member's Name: ____________________________________ DOB: _________________

Health Care Recommendations by Licensed Medical Personnel (Physician, Physician's Assistant, or Nurse practitioner). Please attach immunization record.

BP_________ Weight____________ Height_________

I have examined the above camp participant and in my opinion his/her health status does____/does not_____ preclude participation in an active camp program.

Is the applicant under the care of the physician for any conditions? If so, please list:

Recommendations and Restrictions while at camp:

Is the applicant's Tetanus shot up to date? Yes No

Medically prescribed meal plans or dietary restrictions:

Allergies:

Prescriber's original signature/signature stamp:

____ Date: _________________

Printed Prescriber: Prescriber address and phone number:

_____________________________________ ____

____

Medications to be taken at camp

____ ____

____ ____

____ ____

____ ____

____ ____

Member's signature________________________________ Date: _________________