DECOMA DAY CAMP
3851 N. Mission Hills Road
Northbrook, Illinois 60062

Tel: 847/945-4455
Fax: 847/945-2131
Email: decomadaycamp@aol.com

CAMPER'S MEDICAL EXAMINATION

CAMPER'S NAME _____ _____
Last First Middle Birthdate

PARENT'S AUTHORIZATION: This information is correct and the child described has permission to participate in all camp activities except as noted on this form. I understand that the camp has limited healthcare on site and that staff will call the indicated parent/guardian (a) in an emergency, (b) if questions about my child's health may arise, and/or (c) when my child is unable to continue becuase of injury or illness. I acknowledge that the program wll handle medication as described and that information on this form will be shared with staff on a need-to-know basis.

Signature of Parent or Guardian: _____Date_____

Health History (give dates if known)

Allergies

Asthma

Convulsive disorder

Diabetes

Heart Disease

Serious illness,
injuries or surgery

Immunizations

Immunizations comply with state law:
Yes_____ No_____

If no, please list deficient Immunizations:

Tetanus Toxoid (date) _____

TB Test: Date_____ Type_____

Results_____

HT _____

WT _____

BP _____

PHYSICAL EXAMINATION

Significant Physical Findings:_____

Please indicate any long-term medication being given and state reasons:_____

_____

Medication to be administered at camp: _____ dosage_____ time of day _____

reason for taking_____

May participate in all physical activity: Yes___No___ If no, specify changes or restrictions:

_____

_____

Dietary restrictions or food allergies:_____

Physician's Name_____

Physician's Signature_____ Exam Date:_____

Address:_____Phone No._____

Please add any other pertinent information below or on back of this form.