Session: (please circle):
1 2 3 4 5 6

Stamford Museum & Nature Center

PHYSICIAN'S EXAM/RECORD

*****A valid school physical or copy of recent physical may be substituted for this form.*****

Date of Exam (within 3 years) _____

Name _____ Date of Birth _____

Guardian _____ Address _____

Home Phone _____ Cell Phone _____

Emergency Contact _____ Telephone _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

GENERAL APPRAISAL:

_____ May participate in all camp programs

_____ May participate except for: _____

_____

Medical information pertinent to routine care and emergencies: _____

_____

Is this individual taking prescription or over the counter medication(s)? ☐ YES ☐ NO

If yes, indicate names of medication(s): _____

_____

Does the individual have allergies? ☐ YES ☐ NO Explain: _____

Is the Individual on a special diet? ☐ YES ☐ NO Explain: _____

Does the individual have special needs? ☐ YES ☐ NO Explain: _____

This camper is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Print name of medical provider: _____

Medical Care provider's address: _____

_____

Signature of Physician, APRN or PA _____

Date Form Signed: _____

Telephone Number: _____

All forms must be into SM&NC **ONE WEEK** before the start of your child's first camp!