Your Connection To Nature

Date Received:	
Date Revised:	

2017 CAMP PHYSICIAN FORM

Must be completed by a Physician and submitted 1-week prior to attendance in Camp!
No child will be allowed to attend camp without this completed Camp Physician Form on file.
No Medical Form, No Camp! $25.00 late processing fee due will all medical forms if submitted less than 7 days before camp session begins.

Dear Doctor,
Your patient has enrolled in the Marine Explorers Summer Camp @Cedar Beach Marina, Babylon. The summer camp will engage your patient in activities and experiments in various areas of scientific study. Activities will include daily outdoor beach and marsh hikes, seining, handling marine wildlife such as fish and **shellfish**, fishing on a charter fishing boat, indoor arts and crafts, and general recreational games. Please complete the form below and include any restrictions needed to keep your patient healthy and safe during their time at Marine Explorers Camp.

Camper Name: ☐ M ☐ F		**DOB:**
PERSONAL HEALTH HISTORY		
Immunizations and dates:	☐ Tetanus	☐ Polio
	☐ Diphtheria	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any allergies to:	
Medication Allergies (penicillin, etc.):	Reaction:
Insect Allergies (bee sting, etc.):	Reaction:
Inhalation Allergies (pollen, dust, etc.):	Reaction:
Contact Allergies (**shellfish**, **fish**, latex, etc.):	Reaction:
Food Allergies (peanuts, chocolate, etc.):	Reaction:

Medical Conditions:
Epilepsy, diabetes or asthma?
ANY other patient medical conditions, communicable diseases, or other? (Attach records if needed):
Any restrictions on activity or exercise?
Any physical disabilities?
Does your child carry an epi-pen, inhaler, or other:

Any medications the patient will be taking during camp? (Medications are supplied by parent / guardian)		
Name:	Dose/Time:	Reason:
Name:	Dose/Time:	Reason:
Name:	Dose/Time:	Reason:
Herbal/Non-Prescription Meds:	Dose/Time:	Reason:

I believe this child is able to attend and participate in Marine Explorers Summer Camp:	☐ Yes	☐ No
I give my permission for the camp nurse to administer the above-listed medications:	☐ Yes	☐ No

Physical Examination Date: _____ ☐ Check if Exam Records are attached.

_____ Physician's Signature

_____ Physician's Name – Please Print

_____ Date

_____ NYS License Number