Allaire Country Day Camp

Doctor's Health Release

2903 Highway 138 eas
Wall, NJ
07719

Phone: (732)681-4651

This form must be completed by a Licensed Physician and returned with the Registration Form.

CHILD'S NAME: ____ ***Grade in Sept. 2010:*** ___________

Immunization History

Vaccines	*DATES*					
DTP						
Haemophilus Influenza b (HIB)						
Polio						
Measles/Mumps/Rubella (MMR)						
Hepatitis B						
Tuberculin Test Given						
Pneumococcal Conjugate (PCV)						
Varicella						
Other: ________________________						

Physician's Health Care Recommendations

The last date I examined the above applicant was (Date Examined)		
The above's condition ☐ DOES ☐ DOES NOT preclude his/her participation in a summer camp/after school care program.		
Height	Weight	Blood Pressure
The applicant is under the care of a physician for the following condition(s):		
Current treatment (include current medications):		
Explanation of any reported loss of consciousness, convulsion, or concussion:		
Does Applicant have epilepsy? ☐ Yes ☐ No	Does Applicant have diabetes? ☐ Yes ☐ No	

Recommendations & Restrictions While at Summer Camp

Any treatment to be continued at site?
Any allergies (food, drugs, plants, insects, etc.)?
Any medication to be administered at site (specific dosages)?
Additional health information

PHYSICIAN'S SIGNATURE

Licensed Physician's Signature	
Address:	Phone #
Date Form is Completed:	If Form Completed by Nurse, please initial: