Camper Name _____ **Date of Birth** _____

Healthcare recommendations by licensed healthcare provider for _____
Name of camper

This examination report page is to be completed and signed by the participant's primary care provider. It must be based on an exam completed during the school year prior to the beginning of camp.

Date of exam _____

Blood pressure _____ Weight _____ Height _____

In my opinion, the applicant ❑ is ❑ is not able to participate in an active camp program.

The camper is under the care of a physician for the following condition(s) _____

_____

_____

_____

_____

Active treatment at the time of this report includes _____

_____

_____

_____

_____

Recommendations and restrictions for camp program

Treatment to be continued at camp _____

_____

_____

Medications to be administered at camp (name, dosage, frequency) _____

_____

_____

Any medically-prescribed meal plan or dietary restrictions _____

_____

_____

Known allergies _____

_____

_____

(Note: Allergy desensitization treatments will only be permitted with a doctor's written order)

Description of any limitations or restrictions of camp activities _____

_____

_____

Additional information for the camp health care staff _____

_____

_____

_____

- **Please include a copy of immunization record with this form**

Signature of licensed healthcare provider _____ Date _____

Printed Name _____ Phone _____

Address _____
Street address City State Zip Code

New England Music Camp - Permission to Treat

Campers Name: _____
Last *First* *Middle*

Home Address: _____
Street

_____
City *State* *Zip Code*

Medical Permissions

Permission to provide necessary treatment or emergency care: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests or treatment; to release any records necessary for insurance purposes; and to provide or arrange related transportation for me or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips outside of camp.

I also understand and agree to abide by the restrictions placed on my camp activities.

Parent/Guardian Authorization: The health history (provided in camper account) is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

Parent or Legal Guardian Name (Print): _____

Parent or Legal Guardian Signature: _____

Date: _____