CAMPER MEDICAL EXAM FORM

MUST BE COMPLETED
AND SIGNED BY A PHYSICIAN FOR ATTENDANCE.

PLEASE ATTACH IMMUNIZATION HISTORY

Return by June 1

Scan and email as **PDF** to:
camp@willowaydaycamp.com

Upload to:
willowaydaycamp.com/medical

or mail to: **Willoway Day Camp**
PO Box 250933
West Bloomfield, MI 48325
248-932-2123

Medical Personnel: Please complete all sections of this form and attach immunization history. Attach additional information as needed.

Last Name _____ First Name _____

Date of Physical Exam: _____ Weight _____ lbs Height _____ft _____in

Blood Pressure _____/_____ Pulse _____

A physical exam to have been performed within two (2) years of the camper's FIRST DAY OF CAMP.

ALLERGIES ___ No known allergies. This camper is allergic to: ____Food ____ Medicine ____ Environmental (insect stings, pollen, etc.) ___ Other

Please describe below what the camper is allergic to and the reaction seen.

TREATMENTS

The camper is undergoing treatment at this time for the following conditions (including emotional/psychological) (describe below) ____None

MEDICATION

____ No daily medications. ____ Will take the following prescribed medication(s) while at camp: (name, dose, frequency – describe below)

RESTRICTIONS

Do you feel that the camper will require limitations or restrictions to activity while at camp? ____Yes ____No

If you answered "Yes" to the question above, what do you recommend? ***(describe below – attach additional information if needed)***

IMMUNIZATION HISTORY

Please attach a copy of child's immunization history from health-care provider or state and/or local government. **NOTE: We are unable to accept vaccination waivers, except in instances of documented allergy/or medical contraindication.**

A complete immunization history from health care provider or state and/or local government documenting all age-appropriate vaccinations is required before attendance at camp. If you have any questions, please call 248-932-2123.

I have examined the above applicant for entrance to Willoway Day Camp and find him/her physically qualified to be accepted as a camper and to enter into all camp activities, except as noted above.

Physician's Name _____ Signature: _____ Date:_____

Address: _____ Phone Number _____

City _____ State _____ Zip Code _____