



# Physician's Form

CAMBRIDGE SCHOOL OF WESTON  
 GEORGIAN ROAD  
 WESTON, MA 02493  
 PHONE: 781-642-8666

Camper Name \_\_\_\_\_  
Last First  
 Age \_\_\_\_\_ Sex M F Birth date \_\_\_\_\_

## Health Examination by a Licensed Physician

I have examined the above applicant \_\_\_\_\_ Date examined: \_\_\_ / \_\_\_ / \_\_\_

In my opinion, the named camper's condition does \_\_\_ does not \_\_\_ preclude his/her participation in an active summer program.

Current medical problems, recent injuries, operations or chronic conditions:  
 \_\_\_\_\_  
 \_\_\_\_\_

Regular and/or periodic medications and reasons for taking them:  
 \_\_\_\_\_  
 \_\_\_\_\_

Medically prescribed meal plan or dietary restrictions:  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies (food, drug, environmental, etc.):  
 \_\_\_\_\_  
 \_\_\_\_\_

Is an epinephrine pen prescribed? Yes \_\_\_ No \_\_\_

Medications or treatment to be administered during the camp day:  
 \_\_\_\_\_  
 \_\_\_\_\_

Outdoor Games participation: This individual may participate in all camp and athletic activities unless otherwise indicated. Limiting conditions:  
 \_\_\_\_\_  
 \_\_\_\_\_

Additional Health Information:  
 \_\_\_\_\_  
 \_\_\_\_\_

Provider's Name: \_\_\_\_\_

Licensed Provider's Signature: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Date of form completion : \_\_\_\_\_

By \_\_\_\_\_  
 (Initial if completed by nurse or physician's assistant)

Please record the date (month, date, year) of all basic immunizations and booster doses:

Vaccines	Year of Basic Immunization	Year of last booster
DPT/DTaP	1	
	2	
	3	
	4	
OR	5	

TD		
OR		
Tetanus		

Polio	1	
OPV/O{V	2	
	3	
	4	

MMR		
(Measles, Mumps, Rubella)		
Measles		
Mumps		
Rubella		
(German Measles)		

Varicella		
HIB		
Hepatitis B	1	
	2	
	3	

Tuberculin	type	
Test	date	
	result	