

2008 GBC Day Camp Medical Form
(To be completed by physician)

Medical History For _____ DOB: _____

Vaccines	Month/Year of Immunization	Month/Year of Booster
Diphtheria Pertussis (Whooping Cough) DPT Tetanus		
Tetanus Diphtheria		
Tetanus		
Oral Polio (Sabin)		
Injectable Polio (Salk)		
Measles (Hard measles, red measles, Rubeola)		
Tuberculin Test given (most recent)		
Haemophilus Influenza b (HIB)		
Hepatitis B		
Varicella		

Recommendations/Restrictions

Allergies: _____ Treatment: _____

Medication to be administered (include specific doses): _____

Restricted activities: _____

Additional health information: _____

Other physical/emotional limitations: _____

Physician's Statement of Condition/Treatment:

Date of last physical examination: _____

This child is under the care of a physician for: _____

Current treatment, including medications: _____

Child has: Epilepsy Yes/No
 Diabetes Yes/No
 Asthma Yes/No

In my opinion, the child's condition does allow/does not allow (please circle one) full participation in the day camp program.	
Signature of Physician _____	Print Name _____
Date _____	Phone# _____

Please return to: AKA Summer Camp 112 Crawley Falls Road, Brentwood, NH, 03833 Fax: 603-642-9211
We can also accept the generic form provided by many physicians in lieu of side one.

This document contains two pages. Page two is to be completed by the child's parent/guardian

Camp Medical

This portion of the camp medical is to be completed by the child's parent/guardian

Health History

Child's Name: _____ Date of Birth: _____

Allergies: _____ Allergies to insect stings: _____

Asthma: _____ Heart Disease: _____ Diabetes: _____

Convulsions: _____ Seizures: _____ Epilepsy: _____

Hearing Impairment: _____ Sight Impairment: _____

Frequent Headaches: _____ Ear Infections: _____

Operations: _____ Other: _____

Explanations: _____

Regularly taken medications: _____

Please list any possible side effects or overdose symptoms

Insurance Information and Release for Emergency Medical Treatment

If the child is covered by any insurance, please complete the following:

Name & Address of insurance company: _____

Policy Holder Name _____ Policy Number: _____

Policy Holder address if different from child: _____

Relationship of policy holder to child: _____

This is to certify that my child, _____ as her/his parent(s) or legal guardian(s), _____, I/we hereby give consent to the coaches and staff of Action Kids Athletics LLC to administered emergency CPR and First Aid by certified personnel and to obtain medical care from any licensed physician, hospital, or clinic for the above mentioned child for any injury that may arise.

I certify that the medical information of the above named child is accurate. If any limitations exists or arises preventing her/his participation in the programs at Action Kids Athletics LLC., I will bring such to the attention of the nearest employee of Action Kids Athletics LLC immediately. Removal from the participation in the program may be required until such time that corrective action is taken to allow the child resume participation. A doctor's note may also be required.

Date: _____ Signature of parent/legal guardian: _____

Date: _____ Signature of Witness: _____