





## SAFE HARBOR

— PILOTS POINT —

### Part Two – Health Information

#### TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ May participate in all camp activities

\_\_\_\_\_ May participate except for: \_\_\_\_\_

Medical information pertinent to routine care and emergencies: \_\_\_\_\_

Is this individual taking prescription or over the counter medication(s)? ☐ YES ☐ NO

If yes, indicate names of medication(s): \_\_\_\_\_

Does the individual have allergies? ☐ YES ☐ NO Explain: \_\_\_\_\_

Is the individual on a special diet? ☐ YES ☐ NO Explain: \_\_\_\_\_

Does the individual have special needs? ☐ YES ☐ NO Explain: \_\_\_\_\_

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Y	N		Y	N
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Comments: \_\_\_\_\_

Print name of medical care provider: \_\_\_\_\_

Medical care provider's address: \_\_\_\_\_

Medical care provider's: City/Town \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

Signature of Physician, PA, APRN or RN: \_\_\_\_\_

Date Form Signed: \_\_\_\_\_ Telephone Number: ( ) \_\_\_\_\_