# CAMPER HEALTH FORM SUPPLEMENT – Maryland Camps

To Be Completed by Physician/Pediatrician

**Physician/Pediatrician may substitute with his/her own form.*

Camp Name: _____ State in which the camper resides: _____

I examined _____ on _____ and in my opinion, he/she
(camper's name) (date)

□ **is** □ **is not** able to participate in an active camp program.

**Recommendations and Restrictions at Camp:**

Treatment to be continued at camp:

_____

_____

_____

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

*****Please note that parent/guardian must fill out "Authorization to Administer Medication" form if medication is to be administered to your child at camp.***

_____

_____

_____

Known Allergies (please describe the reaction and management of the allergy):

_____

_____

_____

Description of any limitation or restriction on camp activities:

_____

_____

_____

**Record of Immunizations:**

(please fill in or attach record)

| **Vaccine:** | **Dates:** Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr |
|---|---|---|---|---|---|---|
| DTP | ____ | ____ | ____ | ____ | ____ | ____ |
| TD (tetanus/diphtheria) | ____ | ____ | ____ | ____ | ____ | ____ |
| Polio | ____ | ____ | ____ | ____ | ____ | ____ |
| MMR | ____ | ____ | | | | |
| or Measles | ____ | ____ | | | | |
| or Mumps | ____ | ____ | | | | |
| or Rubella | ____ | ____ | | | | |
| Haemophilus Influenza B | ____ | ____ | ____ | ____ | | |
| Hepatitis B | ____ | ____ | ____ | | | |
| Varicella (chicken pox) | ____ | ____ | | | | |

Is the child exempt from any immunizations?

☐ YES ☐ NO

If YES, which ones?

*For campers who reside outside the US:*

Country in which the child resides:

*Attach completed form DHMH-896 which can be obtained from KECamps directly.

**Signature of licensed medical personnel**_____

Printed_____Title_____

Address_____

Phone_____ Date_____

*Please fax to 877.829.5556, email to madeline@kecamps.com or upload to your online registration account through the Register Button at www.kecamps.com.*