

MERROWVISTA 2010 Health Memorandum

Name _____
Program/Session _____

This form verifies the date of child's last physical, and physician recommendations for participation in the camp program.

It must be completed and signed by child's physician.

Return to: Merrowvista; 147 Canaan Road; Ctr. Tuftonboro, NH 03816
Fax: (603) 539-7504 Phone: (603) 539-6607

TO EXAMINING PHYSICIAN OR PHYSICIAN EXTENDER:

Merrowvista's Camp programs are physically and mentally strenuous at times, but an individual with normal mental and physical capacity can usually expect to do well in our programs. Examples of activities in our programs include but not limited to swimming, biking, backpacking, sailing, remote camping, traversing rugged terrain, exposure to the natural elements and using challenge courses that may be 50' high or greater. We appreciate your input as to whether there is any need for further evaluation, specific recommendations, or limitation of this participant in our program.

Name of Child _____ Date of most recent physical examination _____.

Any recent injuries or existing medical condition (chronic or recurring illnesses?) ___ No ___ Yes if yes, please explain

Summary of Active Concerns/Restrictions which would preclude child from participating fully in camp program or in remote wilderness backpacking, bicycle or canoe trips (diet, medical, swimming, athletic, psychological) :
None or list below: (use back if necessary)

Health History (Please check all that apply)

_____ Allergies: Drug ___ Food ___ Environmental ___ Bee Stings ___ Epi-pen required? ___ yes ___ no
Specify & Describe Reaction: _____
_____ Asthma (type) _____ Well controlled? _____ Inhaler ? ___ yes ___ no

If inhalers or epi-pens are prescribed:

Campers prescribed epi-pens or inhalers may be given permission to carry their inhaler or epi-pen with them during camp. Do you have any concerns with this camper carrying their inhaler or epi-pen, their understanding of how to safely possess it, or their ability to self-administer if necessary? ___ No ___ Yes

Medications (ALL medication, INCLUDING Psychological)

Medication & Dosage (mg x daily)	Times of admin	Purpose	Special Instructions

Immunizations: _____ copy attached & verified up to date Date of last Tetanus Toxoid Immunization: _____

TB Risk Assessment – Test not necessary if risk deemed low Low Risk _____ High Risk _____ Test results _____ Date: _____

PHYSICIAN SIGNATURE REQUIRED

Physician Name: _____ How long have you known the participant?: _____

Address: _____ Telephone: _____

Physician signature _____ Date _____