MEDICAL FORM—Required of all participants

PLEASE NOTE: Your child’s blue physical form is sufficient, current within the last 3 years.

Please return to: The Kate, 300 Main Street, Old Saybrook, CT 06475 or email Robin.Menzies@thekate.org

Please submit ASAP and no later than May 1st.

SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER

☐ May participate in all camp activities
☐ May participate except for __________________________________________

Medical information pertinent to routine care and emergencies: __________________________________________
_______________________________________________________________________________________________

Are there any prescription or over the counter medication(s) this individual needs to take while at camp, including EpiPen/inhaler?

☐ Yes ☐ No  If yes, indicate names of medication(s): ________________________________________________

NOTE: A written authorization for the administration of medication at camp is required.

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: ______________________________

NOTE: If the camper has a special health care need or disability that requires special care be taken or provided during camp, an individual plan of care shall be developed with the parent and health care provider.

Is this individual immunized in accordance with the schedule adopted by the Commission of Public Health pursuant to section 19a-7F of the Connecticut General States? ☐ Yes ☐ No

Additional comments: __________________________________________________________________________
_______________________________________________________________________________________________

Printed name of Health Care Provider ____________________________________
Address ________________________________ Phone ________________

Signature of Physician, PA, APRN or RN ________________________________ Date ___________