CAMP SEA LAB

SCHOOL NAME:________________________________

YOUTH HEALTH-CARE RECOMMENDATIONS
by LICENSED MEDICAL PROFESSIONAL

SUPPLEMENTAL FORM for Serious Health Conditions ONLY

****DOCTOR SIGNATURE REQUIRED****

This supplemental medical form must be submitted with **Camp SEA Lab Health Form** on the first day of camp.

For any **serious health condition** that may limit a child's ability to participate in camp activities, this form must be completed by a parent/guardian of the child, *and* a licensed medical professional within 12 weeks of attending camp.

A **serious heath condition** is defined by, but is not limited to, one that:
(A) Requires regular, periodic visits for treatment by a health care provider;
(B) Continues over an extended period of time, including recurring episodes of a single underlying condition (e.g. heart or back conditions, cancer, disease, migraine headaches, severe persistent asthma, etc.); *or*
(C) May cause episodic rather than a continuing period of incapacity (e.g. diabetes, epilepsy, etc.).

SECTION 1: To be completed by PARENT/GUARDIAN and submit with Camp SEA Lab Health Form to Doctor

Participant's Name (please print)	Age	Birth date	Gender ☐Male ☐Female
Names of parent(s)/guardian(s)	Email		
Address (include city and zip)	Day Phone ( ) Evening or Cell Phone ( )		

Dates my child will attend camp: from: ________________ to: ________________ month/day/year month/day/year	X ________________________________ Signature of Parent/Guardian	______________ Date

SECTION 2: To be completed by LICENSED MEDICAL PROFESSIONAL

Please review the patient's **Camp SEA Lab Health Form** and complete all remaining sections on this form. Attach additional information if needed.

Physical exam done today: ❒Yes ❒No If "No", date of last physical: ________________ *(month/day/year)*

2.1 HEALTH CONDITION

The patient is undergoing treatment at this time for the following conditions:

(more on back)

2.2 MEDICATION

☐ This patient will take **no** medications while at camp.

☐ This patient takes medications as follows:

Med #1 ______________________ Dosage_______________ Specific time taken each day ___________________________

Med #2 ______________________ Dosage _______________ Specific time taken each day ___________________________

Med #3 ______________________ Dosage _______________ Specific time taken each day ___________________________

Does this patient carry: An Inhaler? ❒Yes ❒No An Epi-pen? ❒Yes ❒No

2.3 RECOMMENDATIONS

The patient is recommended to participate in the following camp activities:		Only under the following limitations/restrictions:
Strenuous Walking:	❒Yes ❒No	
Running:	❒Yes ❒No	
Hiking (1-2 mi):	❒Yes ❒No	
Kayaking:	❒Yes ❒No	

Any accommodations that should be made:

2.4 AUTHORIZATION

I have reviewed the patient's **Camp SEA Lab Health Form**, and have discussed the camp program with the patient's parents(s)/guardian(s). It is my opinion that the patient is physically and emotionally fit to participate in an active camp program (except as noted above).

Name of Licensed Medical Professional (please print) ____

Medical License Number#: _______________________________ Telephone Number: ( ) -

Medical Office Address: ____

Street *City* *State* *Zip Code*

X ____

Signature of Licensed Medical Professional Date