VRAJ YOUTH CAMP

Medical Clearance Form

(To be **received** before May 26,' 2018 to avoid **$50 late fee**)

TO BE COMPLETED BY PHYSICIAN AFTER MARCH 1st, 2018:

Participant's Name: _____DOB:_____ Registration No. _____

Medical condition(s): _____

Food, environmental or drug allergy: _____

Severity of allergy: [ ] None [ ] Mild [ ] Moderate [ ] Severe Trigger(s): _____
Asthma: [ ] None [ ] Mild [ ] Moderate [ ] Severe

_____

Name of medication(s): _____

Length of time and frequency of dosage: _____

Does participant need to carry any emergency medicine? Yes _____No_____

Please specify: _____

Are there any restrictions? Yes _____ No____. If yes what and for how long?

Please specify: _____

_____

Please check one:

☐ I certify that my patient is **capable** to attend camp and is free of any communicable disease.

Parent/Counselor understands that food may be cross-contaminated. Vraj camp has no physician and is located in rural Pennsylvania with Emergency facility approximately 45 minutes away. Participant is trained (if he/she is prescribed) to administer all regular and emergency medications, including Epipen, **without any other/adult supervision**.

☐ I certify that he/she is **NOT capable** of attending camp.

Extra notes:

_____ _____ _____
Printed Name of Physician Signature of Physician Date

Physicians
Emergency Contact number: _____

Office Stamp