SAINT MICHAEL'S SUMMER CAMP
WHERE ALL BOYS HAVE FUN.

27977 Silverado Canyon Rd, Silverado, CA 92676
Phone: (657) 314-9071 Ext. 271 Fax: (657) 314-9034
www.stmichaelsabbey.com/summer-camp
summercamp@stmichaelsabbey.com

PHYSICIAN'S FORM

If your child has a chronic condition such as **asthma, diabetes, is severely allergic to a particular food**, or is on prescribed medication, this **must be filled out and signed by a physician**. Please attach another page if more space is needed.

Physician's Name: _____ **Phone Number:** _____

Name of Camper (Patient): _____ Age: _____

Date of Physician Examination: _____ Birthdate: _____

Insurance Carrier: _____ Policy Group Number: _____

Height: _____ Weight: _____ Blood Pressure: _____

Applicant is under my care for the following condition(s): _____

Treatment to be continued at camp: _____

Additional health information/major allergies: _____

_____

Medically prescribed meal plan or dietary restrictions: _____

_____

Any report loss of consciousness/seizure/concussions? Yes/No If yes, please explain:

_____

This applicant may participate in all camp activities? Yes/No If no, please explain:

_____

FOR PRESCRIPTION MEDICATION, physician to fill out the following, include **Inhalers/Epipens to be given to the camper to carry.**

Medication 1 Name: _____ For: _____

Amt to be given: _____ Route: _____ Frequency: _____

Medication 2 Name: _____ For: _____

Amt to be given: _____ Route: _____ Frequency: _____

Physician Signature: _____ **Date:** _____

Address: _____

City: _____ Zip: _____