CAMPER HEALTH FORM – PART B - PHYSICIAN

Camper First Name, Camper Last Name:

Instructions
To physician. Please follow the instructions below. Attach additional information if needed. 1) Review Part A of this form. 2) Please Complete and Sign Part B (this form) 3) Attach Immunization Records 4) Return to Physician/Guardian for submission to Seeds of Peace (Camp@seedsofpeace.org)

Camper Information	
Camper Name	
Birthdate (MM/DD/YYYY)	
Sex Assigned at Birth (male/female)	
Gender (male/female/nonbinary /trans)	
Physical Exam completed today?	Yes / No If No, date of most recent examination: _____ If the date of examination was not completed in the last 12 months, the camper must complete a physical examination.
Height	
Weight	
Pulse	
Blood Pressure	

Treatment
This camper is receiving care from a physician or therapist for the following conditions (physical and mental health conditions, including behavioral difficulties, eating disorders, severe anxiety or depression, ADD, ADHD, etc): ❑ Not Applicable
This camper should continue to receive the following treatment/therapies while at camp:

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Camper Medical Information

Allergies:
Please list any allergies, severity, reaction, and treatment

Allergy	Severity/What does the reaction look like?	Treatment

Are there any medications (including non-prescription/over the counter) that the camper should **NOT** be given? Please list here:

Diet, Nutrition (check all that apply)

- □ This camper has no limitations in what they can eat
- □ This camper eats a vegetarian diet.
- □ This camper is lactose intolerant.
- □ This camper is vegan.
- □ This camper is diagnosed with celiac disease
- □ This camper eats halal (please describe:)
- □ This camper eats kosher style (please describe:).
- □ This camper keeps kosher (please describe:).
- □ Other. Please describe: _____

Medication:

- □ This camper will not take any daily medications while attending Camp.
- □ This camper will take medications while at Camp (complete below table)

Please fill out as much of the information below as possible. Medications include vitamins, over-the counter medicines such as Advil and Tylenol, birth control pills, or any natural remedies. All medications will be reviewed by the Camp Health Center staff on the day of Camper arrival and stored at the Health Center.

Please send all medication in the original package/containers they come in from the pharmacy, and clearly label your child's name on all medication.

Medication Name	Reason for taking?	When it is given? (circle one)	Amount or dose given?	How it is given? (oral, pill, liquid, shot)
		Breakfast Dinner Other time: _____		

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		Breakfast Dinner Other time: _____		
		Breakfast Dinner Other time: _____		
		Breakfast Dinner Other time: _____		

Inhalers and Epi-Pens:

- □ This camper requires the use of a rescue inhaler
- □ This camper requires the use of a maintenance inhaler
- □ This camper requires the use of an epi-pen

If yes to any of the above, the parent/guardian must complete and return the Allergy and Anaphylaxis Emergency Plan form.

COVID Health History (check "yes" or "no")

Has your patient been diagnosed with COVID-19? □ Yes □No

If Yes, Date diagnosed with COVID-19, Date: _____

If Yes, is this patient cleared for physician activity? □Yes □No

Did your patient receive the COVID-19 vaccine? □Yes □No

Do you have any concerns about this patient's health in regards to COVID-19? □Yes □No If Yes, describe: _____

Please list any allergies or conditions that could mimic symptoms of COVID-19: _____

Mental, Emotional, and Social Health: *Check "Yes" or "No" for each statement.*

Has your patient:

- Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? □Yes □No
- Ever been treated for emotional or behavioral difficulties or an eating disorder? □Yes □No
- During the past 12 months, seen a professional to address mental/emotional health concerns? □Yes □No
- Had a significant life event that continues to affect the camper's life? □Yes □No
- (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below. The camp may contact you for additional information.

Camp Programs and Activities

I understand that these program and activities include: participating in sports, arts, and swimming activities in an outdoor environment; sleeping in a shared cabin with other youth and adults; used shared bathroom and shower houses; participating in dialogue conversations with youth of different backgrounds about identity, lived experience, and issues in their communities; having limited access to phones and technology (no use of personal phone, options to call loved ones at pre-scheduled times 3 times throughout the session); walking between activities outdoors; eating meals in shared cafeteria withsocial distancing and/or outdoors under tent; maintaining COVID-19 protocols ((includes wearing a mask in certain situations, COVID testing before and after arrival).

- □ I have reviewed the program and activities of the camp and the camper can safely participate in all activities without restrictions.
- □ I have reviewed the program and activities of the camp and the camper can safely participate in activities with the following restrictions

  Please describe: _____.
- □ I have reviewed the program and activities of the camp and the camper cannot safely participate in the Camp program.

Physician Contact Information and Signature

Name of primary care physician: _____

Email:_____ Phone: _____

Signature of Licensed Medical Professional: ____ Date: _____

PLEASE ATTACH IMMUNIZATION RECORDS.

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IMMUNIZATIONS

Please ATTACH the camper's IMMUNIZATION FORM to this document or use the form below (including immunizations for the following: Dtap or Tdap, Dt or Tdap, MMR, IPV, HIB, PCV, Hepatitis B, Heptatis A, MCV5, TB, COVID-19).

Is the patient high risk for TB? □ Yes □No

If yes, date of TB test:_____□ Negative □Positive

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent
Diptheria, tetanus, pertussis(DTaP) or (TdaP)						
Tetanus booster (dT) or (TdaP)						

Mumps, measles, rubella(MMR)				
Polio(IPV)				
Haemophilus influenzae type B (HIB)				
Pneumococcal (PCV)				
Hepatitis B				
Hepatitis A				
Varicella (chicken pox)				
Meningococcal meningitis (MCV4)				
COVID-19 (required)				