Camper Name:_____ DOB:_____ Home Phone: (_____) _____

TO BE COMPLETED BY LICENSED PHYSICIAN /HEALTH CARE PRACTITIONER

Height ft. in. Weight lbs. Are immunizations up-to-date? YES ❑ NO ❑

Does this child have any of the following allergies?

- ❑ Peanuts; Reaction:_____
- ❑ Tree Nuts; Reaction: _____
- ❑ Eggs; Reaction: _____
- ❑ Fish; Reaction: _____
- ❑ Wheat; Reaction: _____
- ❑ Insect Venom; Reaction: _____
- ❑ Seasonal; Reaction: _____
- ❑ Dairy; Reaction: _____
- ❑ Shellfish; Reaction: _____
- ❑ Soy; Reaction: _____
- ❑ Latex; Reaction: _____
- ❑ Drug; Reaction: _____
- ❑ Other; Reaction: _____

❑ ADD/ADHD ❑ ASTHMA ❑ CARDIAC CONDITION ❑ SEIZURE DISORDER
❑ ANXIETY/DEPRESSION ❑ BLEEDING DISORDER ❑ DIABETES ❑ OTHER

Please Explain:_____

Past Surgical History:_____

Please describe child's present state of physical and psychological health:

_____

Does this child have any limitations or restrictions on their physical activity? NO ❑ YES ❑

Please Explain: _____

MEDICATION CONSENT SECTION: TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDERS ONLY

****Attention Health Care Providers:**

This section must be completed for any emergency medications (asthma inhalers or injectable epinephrine for allergies) that the camper may require while at camp. Families will be asked to provide medications in their original container with health care provider prescription. **All campers with ANY food allergies are required to have an injectable epinephrine pen with them while they are with us at camp**. **Please note**: In order to provide the highest quality of care for all campers with food allergies we follow the guidelines set forth by the American Academy of Allergy, Asthma and Immunology, who recommend that when a potentially life-threatening reaction to food occurs, injectable epinephrine is used as first line therapy. ***We only permit emergency medications at our camps: Epinephrine injection for food allergies or rescue inhalers for asthma. Campers must be able to self- medicate***. For any questions about this policy, please contact us at 610-668-7676.

1. Medication_____ Dose/Route/Frequency _____ Indication _____
2. Medication_____ Dose/Route/Frequency _____ Indication _____

*IF THIS CHILD HAS FOOD ALLERGIES &/OR ASTHMA & WILL HAVE A RESCUE INHALER WITH THEM AT CAMP:

Child may self administer inhaler: YES ❑ NO ❑

Select one: ❑ Inhaler must remain with child during all activities ❑ Inhaler may remain in Health Office/Area

The above mentioned child has undergone a health evaluation within the past year and may fully participate in all ESF Summer Camp Programs.

Date:_____**(must be signed within one year of camp start date)**

Health Care Provider's Name:_____

Health Care Provider's Signature:_____

Telephone Number:_____

If you would like to speak to someone from our camp about this child, please call: **(800) 529-2267 Ext. 8348 (Please upload to your online account in Active.)**

Physician Name & Address: (Please use a stamp or print)