2018 Physician Statement for *Catholic Charities Camp I Am Special*

All Physician Statements require the Physician's Medical Stamp, contact information, and *must* be MAILED or FAXED directly from their office to 904.230.7465

CAMPER'S Name: _____ **Date of Birth:** _____

Parent's/Guardian's Name: _____ **Doctor's Name:**_____

Medical Diagnoses:

Primary:_____

Secondary:_____

Allergies: _____ ☐ No known allergies

Is this camper capable of participating in this camp?

Physically? Yes ___ No ____ Limitations:_____

Mentally? Yes ___ No ____ Limitations:_____

Diet/Nutrition: ☐Eats a regular diet

☐Has a medically prescribed meal plan or dietary restrictions as described here:

_____.

Is this camper FREE of Communicable Diseases? ☐ Yes ☐ No

If No, Please Explain:_____

Date of Last Tetanus Shot and/or Booster?_____

Prescription Medications:

Name of medication_____ Dosage_____ Frequency_____

Name of medication_____ Dosage_____ Frequency_____

Name of medication_____ Dosage_____ Frequency_____

Name of medication_____ Dosage _____Frequency _____

Name of medication_____ Dosage _____ Frequency _____

Physical Exam Done Today: ☐ Yes ☐No (if no, date of last physical:_____)

ACA accreditation standards specify physical exam within last 12 months.

TREATMENTS: If camper needs any Medical Treatments or Procedures while at camp, our *Medical Treatment and Procedure Protocol Form* needs to be faxed from the physician's office, as well.

Procedure:_____ Frequency_____

Procedure:_____ Frequency_____

Physician Phone: _____Physician's Signature: _____Date: _____

Physician Stamp:	Healthcare Coordinator Stamp:

Catholic Charities Camp I Am Special

235 Marywood Drive * St. Johns, Florida * 32259 * 904.230.7447 * Fax 904.230.7465 * Email: CampIAmSpecial@ccbjax.org