



**Berkshire Hills 2019 Health Exam Form**

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_

**Health Care Recommendations by Licensed Medical Personnel**

I examined the above child on this date: \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, this child is able to participate in an active camp program.

This child is under care of a physician for the following conditions and the physician has the following recommendations and/or restrictions for the camper's time at camp (please include allergies/special diet):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medication: My child's physician and I give the camp permission to administer all of the following medications in generic or brand form as available except the ones I cross out based on the dosage, schedule and for the indications per the medication label instructions. Any medication taken daily by your child must be ordered through our medication service which packages medicines in individual doses.

***OTC Medications: These are stocked by camp for use in case of illness.***

Dramamine    Acetaminophen    Zyrtec    Allegra    Sudafed    Mylanta    Mira Lax    Throat Lozenges  
Bonine        Ibuprofen        Claritin    Benadryl    Robitussin    Pepto Bismol    Tums        Aloe Vera

**Please list ANY OTHER MEDICATION to be taken by your child (please include schedule and dosage for each medicine) All daily medications in pill form on this list must be ordered through Mountain Meds. We can not give your child any medication not listed here or above.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional Information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE OF LICENSED PHYSICIAN:** \_\_\_\_\_

Printed Name \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

This health history is correct and accurately reflects the health status of my child, and I give camp permission to administer all the medications listed above. My child has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

**PARENT SIGNATURE:** \_\_\_\_\_

Print Name: \_\_\_\_\_