# Medical Information for Camp Blue Spruce

Date: ______________________________

Patient/Camper Name: _______________________________________________________________

Patient/Camper Birthdate: __________________________

Physician's Name: ____________________________________________________________________

Physician's Contact: Phone: ______________________ Email: ____________________________

This child is fit for camp _______ Yes _____ No

If no, please explain:

This child is allergic to the following medications:

This child has the following food allergies or other food restrictions (please specify):

This child takes the following prescribed and over the counter medications in the following dosages at the following times:

| Medication | Dose | Route | Frequency |
|---|---|---|---|
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I understand that typing my name below constitutes a legal signature confirming I acknowledge and agree to the information shared on this form.

Physician Signature: _________________________________________________ Date: _______________