



Kay's Kamp

Physician/PNP Recommendations and Restrictions at Kamp

THIS PAGE TO BE COMPLETED BY PHYSICIAN OR PNP

(Fax to: 302-836-8534)

I examined _____ on _____
Camper's Full Name Date of Most Recent Examination

Weight: _____ Height: _____ BMI: _____ BP: _____ HR: _____ RR: _____

Last blood count: Date: _____ Hgb _____ Hct _____ WBC _____
Platelets _____ ANC _____ Varicella Titer _____

Current physical and medical condition: X=within normal limits O=see remarks below

____ scalp, skin ____ heart ____ vision ____ ear, nose ____ lungs
____ hearing ____ throat ____ abdomen ____ neck ____ eyes
____ genitalia ____ teeth ____ extremities ____ lymph nodes ____ nervous system

REMARKS: _____

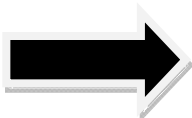
Current Chemotherapy: Please include a copy of current chemotherapy roadmap or regimen.

I have read Kay's Kamp policies regarding CVL's and water sports/activities. **Yes** **No**
(Available online at: kayskamp.org/applications.htm)

Description of any limitation, concern or restriction on Kamp activities:

Any medically prescribed meal plan or dietary restrictions:

I hereby verify that the information on the above form and preceding forms containing health matters and medications are correct. In my opinion, this child is able to participate in Kay's Kamp Summer Kamp.



Signature of Physician/Practitioner _____
Print Name _____ Date _____
Phone _____