2026 PHYSICIAN'S STATEMENT

To insure that Adventure Camp can serve your child, your child **WILL NOT BE PERMITTED** to attend Variety Adventure Camp without a completed Physician's Statement signed by a physician. If you have an immunization list/card, it can be copied and attached.

FILL IN CHILD'S NAME AND FORWARD TO YOUR PHYSICIAN.

Child's Name _____ Birth Date:_____

Weight: _____lbs Height _____ Is the current examination normal? Yes _____No_____

Note any unusual findings: List name of drug(s) currently used, dosage, frequency needed:

_____

List any known allergies (drug, food, plants, insects):

_____

IMMUNIZATION DATES: (Please complete this section or attach a copy of the current immunization record.)

DPT: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____

POLIO: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____

MMR/MR: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____

HIB: _____TB: _____ Reaction: _____

HEP-B: 1. _____ 2. _____ 3. _____

Is child under a physician's care for any conditions? If so explain:

_____

_____

Is any treatment/medication needed during the camp day? _____

Is child under any dietary restrictions? If so, please explain:_____

_____

Please mark information pertinent to this child:

_____ Anxieties	_____ Heart Defect/Disease	_____ Developmental Disability
_____ Hearing Deficiency	_____ Asthma	_____ Attention Deficit Disorder
_____ Behavioral Disorder	_____ Down's Syndrome	_____ Speech Delay
_____ Glasses/Contacts	_____ Hearing Aids	_____ Tourette's Syndrome
_____ Seizure Disorder	_____ Orthopedic Disability	_____ Wheelchair
_____ Crutches	_____ Cane	_____ Walker

_____ Incontinent [ ] Past [ ] Present

Any other special concerns (including behavioral)

_____

Date of Exam: _____ **Physician's Signature:** _____

Type or print Physician's name: _____ **Date Signed:** _____

***Must be within one year of camp attendance.**