Sesame/Rockwood Camps
Rockwood Adventures Teen Travel

Note: Your child may not begin camp until this form is on file at camp.

Physician Health Certification for Campers / or Teen Travel

To be Completed by Licensed Physician. Return ASAP, but please, no later than: APRIL 15th

Camper Name _____ Birthdate _____
First Name *Last Name*

Camper Immunization History: Required immunizations may be determined locally. Please record the date (month & year) of basis immunizations and most recent booster doses. Parent or Physician may attach a copy of child's immunization records.

BIRTH - 6 YRS	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	4-6 years
HepB									
RV (Rotavirus)									
DTaP									
Hib									
PCV (Pneumococcal)									
IPV (Polio)									
Influenza (yearly)									
MMR									
Varicella									
HepA									

7 - 18 YEARS	7-10 years	11-12 years	13-18 years
Tdap (Tetanus, Diphtheria, Pertussis Vaccine)			
HPV (Human Papillomavirus)			
MCV4 (Meningococcal Conjugate Vaccine)			
Influenza (yearly)			

Health Care Recommendations by Licensed Physician: (this portion must be completed to attend camp)

I have examined the above camp applicant within the past two years. *Date examined* _____
Do not leave blank.

Height: _____ Weight: _____ Blood Pressure: _____

The applicant is under the care of a physician for the following condition(s): _____

_____

Current treatment (include medications) _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Is there a history of epilepsy? Yes ☐ No ☐ Is there a history of diabetes? Yes ☐ No ☐

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp _____

Any medications to be administered at camp (specific dosages) _____

Any medically prescribed meal plan or dietary restrictions _____

Any allergies (food, drugs, plants, insects, etc.) _____

Activities to be encouraged or limited _____

Additional Health Information (use reverse side if necessary) _____

icensed Physician's Signature/Stamp _____

Address _____ Phone _____

Date of Form Completion _____ *By _____ *initial if completed by nurse or physician's assistant

Return completed form (one page) to **Sesame/Rockwood Camps • PO Box 385 • Blue Bell, PA 19422 • Fax 610-279-4463**