VRAJ YOUTH CAMP

Medical Clearance Form

(To be **received** before May 17, 2016)

TO BE COMPLETED BY PHYSICIAN AFTER MARCH 1st, 2016:

Child's Name: ________________________________DOB:___________ Registration No. _____________

Medical condition(s): ____

Food, environmental or drug allergy: ____

Name of medication: ____

Length of time and frequency of dosage: ____

Does child need to carry any emergency medicine? Yes _____No______

Please specify: ____

Are there any restrictions? Yes_____ No____. If yes what and for how long?

Please specify: ____

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Please check one:

☐ I understand that Vraj camp is located in rural area of Pennsylvania and there is no Medically trained person available at Vraj Camp. My patient is trained (if he/she is prescribed) to administer all Emergency medications, including Epipen.
I certify that my patient is **capable** of attending camp and is free of any communicable disease.

☐ I certify that he/she is **NOT capable** of attending camp.

Extra notes:

_____________________________	_____________________	_________________
Printed Name of Physician	Signature of Physician	Date

Physicians
Emergency Contact number: ______________________

Office Stamp

February 2016