# Medical Form - Required of all campers

**PLEASE NOTE:** Your child's blue physical form is sufficient, current within the last 3 years.
Please return to: **Community Music School,** P.O. Box 387, Centerbrook, CT 06409
**Due within two weeks of receiving this packet**

Child's Name_____ DOB _____
Parent/Guardian_____
Address _____
City _____State_____ Zip _____
Home Phone_____ Cell_____ Work_____
Medical Insurance Carrier_____ ID #_____
Named of Insured _____

## SECTION BELOW TO BE COMPLETED BY MEDICAL PRATICIONER:

☐ May participate in all camp activities

**Date of Exam ___ /___ /___**

☐ May participate except for_____

_____

Medical information pertinent to routine care and emergencies:_____

_____

Is this individual taking prescription or over the counter medication(s)? ☐ YES ☐ NO If yes, indicate names of medication(s):

_____

Will the individual need the medication(s) during camp hours? ☐ YES ☐ NO
(If YES, please submit a **Medication Authorization Form**)

Does the individual have allergies? ☐ YES ☐ NO Explain: _____

Is the individual on a special diet? ☐ YES ☐ NO Explain: _____

Does the individual have special needs? ☐ YES ☐ NO Explain: _____

This camper is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Measles | ☐ | ☐ | Hepatitis B | ☐ | ☐ |
| Mumps | ☐ | ☐ | Diptheria | ☐ | ☐ |
| Rubella | ☐ | ☐ | Pertussis | ☐ | ☐ |
| Chickenpox | ☐ | ☐ | Pneumococcal Conjugate | ☐ | ☐ |
| Tetanus | ☐ | ☐ | Polio | ☐ | ☐ |

Comments:

_____

_____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town_____ State_____ Zip_____

Telephone Number: _____

_____
Signature of Physician, PA, APRN or RN Date

FOR OFFICE USE:
☐ S1 ☐ S2 ☐ S3 ☐ S4 ☐ S5
☐ SSP