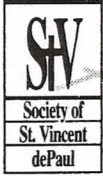


St. Vincent de Paul Camp



1298 Main Street
 Buffalo, New York 14209
 Phone (716) 882-3360
 Fax (716) 882-3556

Residential and Day Campers
Your doctor must sign both blue medical forms.
Parent must sign both blue medical forms.

	In	Out
Date		
Wt		
Clinic Use		

HEALTH CARE RECOMMENDATIONS *by Licensed Medical Personnel*

Camper/Staff Member Name _____

I have examined the above camp participant. Date of last examination _____ BP _____ Weight _____ Height _____

In my opinion, the above applicant: _____ is _____ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

Current treatment at the time of this report includes:

Recommendations and Restrictions at Camp

Treatment to be continued at camp

Medications to be administered at camp

Any medically prescribed meal plan or dietary restrictions

Known Allergies

Description of any limitations or restriction on camp activities

Additional information for health care staff at the camp

➔ Signature of Licensed Medical Personnel _____	
Printed _____	
Date _____	Phone Number _____

Permission to Provide Necessary Treatment or Emergency Care	
I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.	
★ Signature of parent or guardian or adult camper/staffer _____	
Witness _____	Date _____

IMPORTANT - THESE BOXES MUST BE COMPLETE FOR ATTENDANCE