DOCTORS – PLEASE COMPLETE AND FAX THIS FORM TO: (818) 337-2423

DOCTOR'S HEALTH FORM

To Parents: All questions must be answered completely by your child's doctor prior to the start of camp. Your child will not be able to attend camp if this form is not completed and on file in our office prior to your child's first day. Questions? Call (818) 932-4600

To Physicians: This form must be completed before your patient may attend camp. Please answer the following questions and fax this form back to us as soon as possible. **Our fax number is (818) 337-2423**. Questions? Call (818) 932-4600.

CHILD'S NAME:	SEX:	BIRTH DATE:

DATE OF LAST EXAM:	SPECIFIC IMMUNIZATION/ BOOSTER DATES:	DPT/TD	POLIO	MMR	TETANUS

1. Is there any reason why this child is not physically/emotionally able to participate in all camp activities? **YES / NO (If yes, please explain.)**

2. Does child have any physical/emotional conditions that require special attention in a beach camp/aquatic setting? **YES / NO (If yes, please explain.)**

3. Does this child have any special problems or physical limitations we should be aware of? **YES / NO (If yes, please explain.)**

4. Is this child under care for any medical conditions? **YES / NO (If yes, please explain.)**

5. Has this child had any operations or serious injuries? **YES / NO (If yes, please explain and provide dates.)**

6. Is this child currently taking medication and/or receiving treatment? **YES / NO (If yes, please explain.)**

7. Does this child have any history of loss of consciousness, convulsions, concussions, epilepsy, or diabetes? **YES / NO (If yes, please explain.)**

8. Does this child have any allergies (food, drugs, environment, etc.)? **YES / NO** (**If yes, please explain.)**

9. Has this child ever required any psychological or psychiatric counseling or hospitalization? **YES / NO (If yes, please explain.)**

10. Please describe this child's social and motor skills.

11. Is there any additional health information you feel we should be aware of? **(If yes, please explain.)**

PHYSICIAN'S SIGNATURE: **DATE:**

PRINT PHYSICIAN'S NAME HERE:

ADDRESS: **PHONE:**

Doctors – Fax completed form to (818) 337-2423

Or mail to:

Aloha Beach Camp • PO Box 5338 • West Hills, CA 91308