MEDICAL APPLICATION
For Child's Doctor to Complete

Physician's Office - Please Complete This Section

Last Name: First Name: Date of Birth:

Physician's Name:

Practice Name:

Physician's Address: Street:

City: State: Zip Code:

Office Phone:

Office Fax:

After Hours Contact Numbers:

Date of child's last exam or office visit:

Child's diagnosis and original date of diagnosis (Please indicate if in remission):

**** With this application, children with Cystic Fibrosis must provide sputum culture proof of no multiple drug resistant pseudomonas****

Culture Done: n/a:

Other diagnosis, not related to primary diagnosis:

Other helpful information:

Medication given to your child at home (Attach a separate sheet if needed)

Medication Name	Amount Given	How Often

Please list medications the child should take while at Camp during the week of June 10th-15th, 2013

Medication Name	Dosage	Administration Schedule

Any known allergies to medications (Please List): _____

Is the child allergic to any medications: ☐ Yes ☐ No

If Yes, please list: _____

_____

_____

Any Latex allergies? _____

Has the child had Chicken Pox? _____

Any treatments or surgeries prior to Camp? _____

Any diet restrictions while at Camp? _____

_____

_____

_____

Any lab work required while the child is at Camp? _____

Immunization Record: (Please attach a copy of an existing record if available, or complete section below)

DTaP/Hep B/IPV	#:	Date:		Polio	#:	Date:	
Hepatitis B	#:	Date:		Pneum Conj (PCV)	#:	Date:	
DtaP/DT/Td	#:	Date:		**MMR**	#:	Date:	
DtaP/Hib	#:	Date:		Varicella	#:	Date:	
Td Booster	#:	Date:		Hepatitis A	#:	Date:	
Hib	#:	Date:		Meningococcal	#:	Date:	
Hib/Hep B	#:	Date:					
Tdap	#:	Date:					

The enclosed information status on the above named child is accurate according to the best available information on file.

Signature: _____ Date: _____

Please return this Medical Form

By Mail: **Camp Rainbow**
PO Box 3522
Clarksville TN 37043

NO FAX

By E-mail: Apply@ClarksvilleCampRainbow.org
IF SENT BY EMAIL APP MUST STILL BE SIGNED

Questions can be directed to:
Jereme Miner, Camp Director, 931-320-3473.

Parents Complete This Section Only

By sending this form, I give my permission to release medical information to the Camp Rainbow staff and physician. I also understand this medical information will be reviewed with my child's assigned Camp Rainbow counselor(s) for this year's camp session.

Signature: _____ Date: _____