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

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: _____