



VRAJ YOUTH CAMP

Medical Clearance Form – Counselor under 18 yrs. age

Note that any allergies or medical conditions provided by parents must match this form provided by a physician.

TO BE COMPLETED BY PHYSICIAN

Participant’s Name: _____ DOB: _____

Are all immunizations up-to-date? Yes No . If no, please specify: _____

When was the last tetanus booster shot administered: _____

Medical condition(s): _____

Food, environmental or drug allergy: _____

Severity of allergy: None Mild Moderate* Severe* | Trigger(s): _____

Asthma: None Mild Moderate* Severe* | Triggers(s): _____

An Action Plan is REQUIRED for Moderate to Severe Allergies

Name of medication(s): _____

Length of time and frequency of dosage: _____

Does participant need to carry any emergency medicine? Yes No

Please specify: _____

Are there any physical restrictions? Yes No If yes what and for how long? _____

Please specify: _____

Please check one:

I certify that my patient is capable to attend camp and is free of any communicable disease.

Parent/Guardian understands that food may be cross-contaminated. Vraj camp has no physician and is in rural Pennsylvania with Emergency facility approximately 45 minutes away. Participant is trained (if he/she is prescribed) to administer all regular and emergency medications, including EpiPen, without any other/adult supervision.

I certify that he/she is NOT capable of attending camp.

Extra notes: _____

Printed Name of Physician

Signature of Physician

Date

Contact Number

Physician Office Stamp →