

**VRAJ YOUTH CAMP**  
**Medical Clearance Form - Camper**

**To be completed by the child's Physician after March 8th, 2026 ----- To be uploaded with Part II by Sunday May 18th, 2026.**

Note that any allergies, medications or medical conditions provided by parents must match what is provided by the physician in this form. **We reserve the right to contact your physician for clarification on medical diagnosis, treatments, etc.**

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

When was the last tetanus booster shot administered: \_\_\_\_\_

Please provide dates of the Measles/Mump/Rubella series: \_\_\_\_\_

Are all immunizations up to date? Yes [ ] No [ ]. If no, please specify: \_\_\_\_\_

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 Asthma & Food Allergies

Does the participant need to carry any emergency medicine- Epinephrine or Inhaler? Yes [ ] No [ ]

Is there any other information you would like to share to make the camper's experience positive?

Example: Does the patient require any special accommodation? \_\_\_\_\_

Please specify: \_\_\_\_\_

Medical Condition	Name of Medication	Dose and frequency

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 located in rural Pennsylvania with an 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.

Additional notes: \_\_\_\_\_

Printed Name of Physician

Signature of Physician

Date

Contact Number

Physician Office Stamp →

