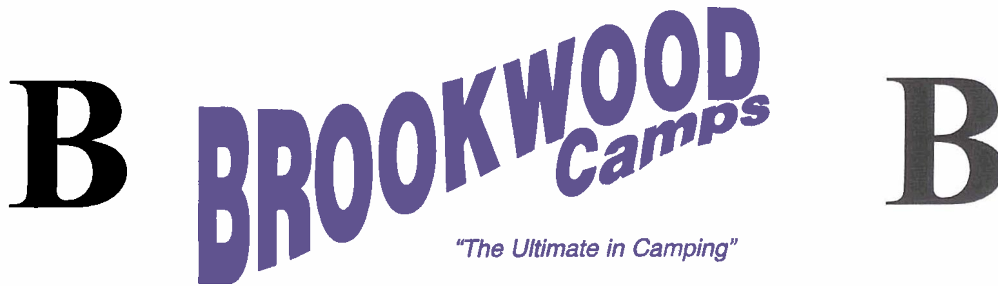
Directors:
Donna Fiedler
Kenneth Fiedler
Scott Fiedler

Associate Directors:
Jo Korder
Ken Korder



MALE CAMPER MEDICAL FORM

TO BE COMPLETED BY PARENT:

Child's Name: ______________________________ Date of Birth: ______________________________

Address: ______________________________ Telephone: Day: (____) ____________________

______________________________ Evening: (____) ____________________

Cell: (____) ____________________

Pertinent Past Medical History:

____
____
____

Please Check all that apply

☐ Ear Infections	☐ Eyeglasses/Contacts	☐ Heart Disease Defect
☐ Seizure Disorder	☐ Diabetes	☐ Asthma
☐ Pneumonia	☐ Headaches	☐ Nose Bleeds

Special Medication (if any):

____
____

IN CASE OF MEDICAL EMERGENCY, I understand every effort will be made to contact parent(s) or guardian of campers. In the event I cannot be reached, I hereby give permission to the physician selected by Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above.

****Parent's Signature**: X ______________________________ Date: ______________

TO BE COMPLETED BY PHYSICIAN:

History:

____
____

Allergies:

____
____

Immunization History: Indicate Date(s) of Immunization

Type	Date(s)	Type	Date(s)	Type	Date(s)
Tetanus		Diptheria		Pertussis	
Measles		Mumps		Rubella	
Polio		Chicken Pox		Hepatitis B	
Haempohilus Influenza-B					

Physical Exam:
Physical Exam Findings:

(Diagnosis): ____

A. If normal, please check ________ Height: __________ Weight: _________
B. Abnormal Findings: ____

____

Name of Physician (Please print or use rubber stamp): ______________________________

Address: ____

Telephone: (____) ____________________

Physician's Signature: ______________________________ Date: ______________

Winter Office:
3242 Judith Lane, Oceanside, NY 11572
Phone 516-764-2112 • Fax 516-536-7725

Summer Office:
Brookwood Camps, Glen Spey, NY 12737
Phone 845-557-6661 • Fax 845-557-6907

Email info@brookwoodcamps.com • www.brookwoodcamps.com