



## Harbor Camps: Camper Health Form FOR PROVIDERS

1. Healthcare provider: please complete & sign this page, and attach signed immunization records.
2. **After completion, parents OR providers:** please send this form PLUS IMMUNIZATION RECORDS to Director Umut Dursun at [umut@harborcamps.org](mailto:umut@harborcamps.org) or 617-507-8464 (fax).

Forms are due as soon as possible. THANK YOU!

This form is for any of our three camps: Harbor Camps, Camp Seneb, or Camp Reflections

Camper Full Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### FOR PROVIDER:

Physical exam done today? \_\_\_ Yes \_\_\_ No If no, date of last physical (must be within 12 mos of camp): \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Blood pressure: \_\_\_\_\_/\_\_\_\_\_

The camper is undergoing treatment at this time for the following conditions **(please include mental health)**:

Other treatments/therapies to be continued at camp (describe below): \_\_\_ None needed

There is a lot of walking and general exercise at our camps. Do you feel that the camper will require limitations or restrictions to activity while at camp?

Complete this question if the camper will take self-administered medication while at camp (e.g., epipen, inhaler). I authorize the camper to self-administer the medications listed below: **please note name of the medication, dosage, frequency, and route.**

### **IMMUNIZATION RECORDS SIGNED/STAMPED BY THE PROVIDER MUST BE ATTACHED.**

Harbor Camps requires the following immunizations be up to date: MMR, DTaP, varicella, and polio. It is also strongly recommended to have the following: meningococcal, hepatitis B, and TB test. *Please note: it is highly encouraged to be up to date on the Covid-19 (SARS-CoV-2) vaccination.* If you believe you have a bona fide medical exemption from our vaccination requirement, we ask you to contact us.

### **PROVIDER'S SIGNATURE:**

I HAVE ATTACHED SIGNED IMMUNIZATION RECORDS. It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as named above):

Name (print): \_\_\_\_\_ Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_ Office address: \_\_\_\_\_ Phone: \_\_\_\_\_

Please see the top for instructions on where to send this **and** immunization records. Thank you.