NATURE'S CLASSROOM AT SARGENT CENTER
PHYSICIAN HEALTH FORM

Sargent Center requires any child attending camp to have had a physical examination within **two** years of attending camp. Physician's orders for prescription drugs to be taken at camp must be written within the current year.

Name of Child ________________________________ was examined on the following date____________ .
Any existing medical condition (chronic or recurring illnesses?) ________________________________
____

Health History (Please check all that apply)

Allergies: □ No known Allergies □ To food (list and describe reaction):	Asthma (Type) Is it well controlled?
□ To medications (list and describe reaction)	ADD or ADHD Is it well controlled?
□ To the environment i.e. insects stings, hay fever (list and describe reaction)	Mood or Mental Health Disorder Is it well controlled?
□ Other allergies (list and describe reaction)	Diabetes (age of onset) Is it well controlled?
Heart Condition (Please specify) Any limitations?	Seizure Disorder (Type) Is it well controlled?

Are there any factors which would preclude this child from participating fully, including a high ropes course, in the Sargent Center program? ( ) Yes ( ) No Specify activities to be limited: ________________________________
____

Date of most recent exam ____________ Last Tetanus Toxoid Immunization ________________________

Note: A record of current immunizations or a properly signed and notarized waiver *must* accompany this form.

Physician's Signature ________________________________**MD Phone (____)** ________________________
Print/Stamp Name

PHYSICIAN ORDERS FOR PRESCRIPTION MEDICATION

(Must be completed and signed by physician in order for Nature's Classroom at Sargent Center to give medications)

Medications must be in original container. The directions on the container must match the physician's written orders. A written order signed by the physician must be received to authorize any change in directions.
Is this child on any prescription medications? ( ) Yes ( ) No

Name of Medication	Date Started	Reason for taking it	When it is given	Amt./dose given	How it is given
			□ Breakfast □ Lunch □ Dinner □ Bedtime		
			□ Breakfast □ Lunch □ Dinner □ Bedtime		
			□ Breakfast □ Lunch □ Dinner □ Bedtime		

Physician's Signature ________________________________**MD Phone (____)**________________________

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