CAMP EAGLE HILL

2026 **Camper** Medical Form (Physician Form) - PAGE 1

Website: www.campeaglehill.com

Email: summer@campeaglehill.com

Summer Office
PO Box 12
Elizaville, New York 12523
Phone (518) 537.4000

Winter Office
33 Barclay Road
Scarsdale, New York 10583
Phone (914) 725.4876

CAMPER'S NAME _____

Date of Birth: /   /

Gender: male   female   other

MEDICAL EXAMINATION *(to be filled in by physician)*

Height _____ Weight _____ BP _____ Hgb._____ Urinalysis _____

1. This child is under the care of a physician for the following conditions:
_____

2. Please state any physical disability that this child has: _____

3. Has this child had any surgery? If yes, for what, and when?
_____

4. Has this child ever had any serious illnesses? If yes, what type, and when? _____

5. Has this child had any recurring illnesses?
_____

6. Are there to be any restrictions for this child while in camp?
_____

7. Are swimming and diving permitted? _____

8. Is strenuous activity permitted? _____

9. Any additional health information or special instructions for this child? _____

10. Any treatment to be continued at camp? _____

11. Any medically prescribed meal plan or dietary concerns? _____

12. Any special instructions for the camp? _____

I have examined_____and have reviewed his/her health history. This health history is correct so far as I know. It is my opinion that he/she is physically able to engage in all activities, except as noted above.

_____ **M.D**
EXAMINING PHYSICIAN'S SIGNATURE

Date of Form Completion _____

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MEDICATIONS TO BE TAKEN AT CAMP *(to be filled in by physician)*

Please list all medications, including all over-the-counter or non-prescription drugs, taken routinely or as needed (PRN). Please bring along enough medication for the stay of camp. In addition, please keep any medication in original packaging so that the original bottle can identify the prescribing physician. (in the case of prescription medication) This will allow us to see the name of the medication, the dosage to be taken, and the frequency of administration.

MEDICATION #1: _____ Dosage _____ Specific Times Taken Each Day _____
Reason For Taking _____

MEDICATION #2: _____ Dosage _____ Specific Times Taken Each Day _____
Reason For Taking _____

MEDICATION #3: _____ Dosage _____ Specific Times Taken Each Day _____
Reason For Taking _____

~ OVER ~