

SEASIDE SAFARI

Environmental Day Camp

HEALTH INFORMATION

SUMMER 2010

To be completed by physician

Child's Name: _____ Date of Birth: _____

Date of last tetanus booster: _____

Dietary restrictions: _____

Allergic reaction to medications: _____

Allergic reaction to bee stings/does this child carry a bee sting kit? _____

_____ Kit: Y N

Other allergies: _____

Heart/respiratory problems: _____ Asthma: Y N

Epileptic or other seizures: _____

Other medical conditions: (recent surgery, major illness, psychiatric treatment, etc.) _____

Is child taking medication?

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Inhaler: Y N **Medication must be provided in original, labeled prescription bottle.**

Other pertinent information Seacoast Science Center staff should know about child: _____

Physician's Statement

I have examined _____ within the past 2 years.

In my opinion, his/her condition does not preclude participation in an active camp program.

Physician: _____ Phone: _____

Address: _____

Signature of physician

Date form signed

Date last examined child

Mail or fax to:



Seacoast Science Center

570 Ocean Boulevard, Rye, NH 03870-2104

603-436-8043

www.seacoastsciencecenter.org

fax: 603-433-2235

Name

File Date

Sessions/