

Last Name

First Name

Birth Date

**Upload:** to your camp account  
**OR**  
**Email:** forms@campdoragolding.com  
**OR**  
**Fax:** (718) 437-7644  
**OR**  
**Mail:** 5515 New Utrecht Ave.  
 Brooklyn, NY 11219



# Camp Dora Golding Medical Form — Physician's Page

## Immunizations:

Immunization Type	Date Basic Series Completed	Most Recent Booster
DTaP / TDaP		
Tetanus		
MMR		
IPV		
HIB		
PCV		
Hepatitis B		
Hepatitis A		
Varicella		
Meningococcal		
H1N1		
Flu Shot		

If any of the immunizations above have not been received, please explain why:

## Physical Exam:

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Height      Weight      Pulse      Blood Pressure      Hct/Hgb. Test      Urinalysis

Eyes	
Glasses	
Ears	
Nose	
Throat	
Heart	
Neuro	

Lungs	
Abdomen	
Genitalia	
Hernia	
Extremities	
Posture (Spine)	
Skin	

General Appraisal:	Medications:
Allergies:	Recommendations:

I have examined the above patient. Date Examined: \_\_\_\_\_ In my opinion his condition  **does** /  **does not** allow participation in an active camp program.

Exceptions: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone #: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_