

PRE-CAMP MEDICAL CLEARANCE FORM SANDY HILL CAMP



The camper's physician must complete all sections on this page and sign at the bottom

Sandy Hill Camp is an active, outdoor residential summer camp where campers will live for 5 or 12 consecutive days. You can contact us by phone at (410) 287-5554, by email to medstaff@sandyhillcamp.com, or by fax to (410) 216-3375 with any questions.

Camper Name _____ Date of Birth ____/____/____
First Name Middle Initial Last Name Month/Day/Year

Name of Physician _____ Phone # _____ Date of Last Health Exam _____

Date of Most Recent Tetanus Shot

Health History

Does the camper have any physical conditions requiring restrictions on participation in an active camp program or which may require emergency action while at camp? **Yes or No (circle one)**

If yes, please describe conditions and restrictions: _____

Is the camper under any current or ongoing treatment or medications? **Yes or No (circle one)**

If yes, explain: _____

Has the camper had a positive diagnosis of COVID-19? **Yes or No (circle one)**

If yes, please list the date of positive viral test: _____

If yes, has the camper met all of the CDC criteria for ending isolation? **Yes or No (circle one)**

Is the camper at higher risk of serious illness if they are exposed to SARS-CoV-2 as defined by the CDC? **Yes or No (circle one)**

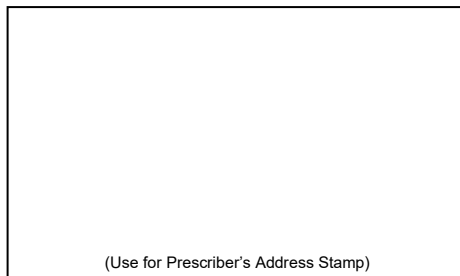
If yes, have you discussed this elevated risk with the camper's parent/guardian? **Yes or No (circle one)**

Please list any other mental, physical or emotional health-related issues that the camp should be aware of: _____

I hereby certify that the above named camper is fit to attend and participate in an active, outdoor, residential summer camp session(s) at Sandy Hill Camp. I know of no impairments which would limit his/her participation in all program activities except those that I have listed above.

PHYSICIAN'S SIGNATURE _____ DATE _____

REV 4/30/2021



(Use for Prescriber's Address Stamp)