

Doctor's Form for Masquebec Hill (Please Complete Both Sides of the Page)

Note for Physicians: At a minimum, please consider, complete and sign the "Recommendations" portion of this form. We would appreciate your completion of the rest of the form, but we can accept and use the medical information in an alternative format, if that is more convenient for you. Mail the form and any attachments to: Masquebec Hill, 1600 Mayhew Turnpike, Bridgewater, New Hampshire 03222. Questions may be directed to Mr. David Hughes, 603-744-5841.

Camper's Name _____
 Physician's Name _____
 Address _____ Telephone _____

Physician's Recommendations

Within the restrictions and under the conditions noted below, it is my opinion that this individual **is / is not (circle one)** medically fit to participate in an active camp program at Masquebec Hill.

Physician's Signature _____ Date of Form Completion _____

Treatments and/or medications to be continued at Masquebec Hill

<u>Condition</u>	<u>Treatment, Medication, Dose, Frequency</u>

Dietary Recommendations/Restrictions while at Masquebec Hill _____

Activities to be encouraged, discouraged, or restricted at Masquebec Hill _____

Immunization Record

Vaccine	Initial immunization Month & Year	Most Recent Booster Month & Year
DPT (Diphtheria, Pertussis, Tetanus) or TD (Tetanus, Diphtheria) or Tetanus	1.	1.
	2.	2.
		3.
Oral Polio (Sabin) TOPV or Injectable Polio (Salk)		
Measles (hard measles, red measles)		
Rubella (German measles, 3-day measles)		
Mumps		
Hepatitis B	Part 1	
	Part 2	
	Part 3	
Haemophilus Influenza		
Tuberculin Test		

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Date of Most Recent Physical Exam: _____ (within the past twelve months)

General Appearance/Impression _____

Data

Height _____

Weight _____

Blood Pressure _____

Pulse _____

Development (Tanner Stage) _____

Cholesterol _____

Other Lab Results (Blood/Urine) _____

Examination

Please check (✓) any areas of concern and explain as necessary. Add attachments as needed.

____ Head/Scalp _____

____ Skin _____

____ Posture/Spine _____

____ Extremities _____

____ Eyes _____

____ Ears _____

____ Nose _____

____ Throat _____

____ Sinuses _____

____ Neck _____

____ Thyroid _____

____ Lymph Nodes _____

____ Heart _____

____ Lungs _____

____ Abdomen _____

____ Genitals _____

____ Hernia _____

____ Rectum _____

____ Allergies _____

____ Diabetes _____

____ Epilepsy _____

____ Asthma _____

____ Emotional Issues _____

____ Chronic Problems _____

____ Other _____