15501 San Fernando Mission Blvd., Suite 100
Mission Hills, CA 91346-9604
818-361-6400 Ext. 111 • 818-365-5523 fax
kim@jaynolan.org
www.jaynolancamp.org

JAY NOLAN CAMP APPLICATION PACKET – SUMMER 2025

We're headed out to the woods, and we're excited for you to join us!
Thank you for choosing to be a part of Jay Nolan Camp!

My name is Kim Cade-Henry. I'm your Camp Director, and your first call if you have any questions or concerns as we prepare your child for Camp.

We know the first questions you have are:

WHEN AND WHERE IS JAY NOLAN CAMP?

Camp Dates are July 27-August 1, 2025
Jay Nolan Camp will be held at *The Lions Camp at Teresita Pines*
(http://www.campteresitapines.org)

AND HOW MUCH DOES IT COST?

2025 Camp Rates

	Dec 1-Feb 29	Mar 1-May 31	June 1- June 24
Campers with a disability	**$1100**	$1250	$1300
Campers without a disability	**$1100**	$1250	$1300

- We are happy to offer some fundraising ideas to involve your friends and family in helping your Camper get to Camp.
- If you believe your child requires 1:1 support, we will be happy to meet with your family for an assessment and work with you to request additional staffing through the Regional Center. Please contact us early so we can get that paperwork started!
- If your Camper requires additional support/supervision and is not a client of the Regional Center, there may be an additional fee. This is determined solely by Camp Administrative Staff.

Turn the page, and let's get ready to go to Jay Nolan Camp!

INSTRUCTIONS

1. Fill out application completely. Include an up-to-date photo, and signed releases.
The application is designed to have all the information needed to help ensure a safe/quality experience for your child.
2. Include payment – a minimum $300 down payment is required at the time of application. Please refer to 'Payment Schedule'. We accept partial payments until we leave for Camp. Please contact Kim to arrange this.
3. Mail, fax, e-mail or drop off application and payment to:

Kim Cade-Henry – Camp Director
Jay Nolan Community Services, Inc.
15501 San Fernando Mission Blvd ste #100
Mission Hills, CA 91346-9604
kim@jaynolan.org
Fax # (818) 365-5523

Medical Examination Form' must be completed/signed by a physician and submitted 30-60 days prior to Camp. Please send in the rest of the application and return the Exam Form when your child has completed their doctor's visit.

Once the Application is processed, a letter of acceptance will be mailed to you. Information on where to meet for Pick-up/ Drop-off, and a list of 'What to Bring', etc., will be mailed one month prior to camp (June 2025).

If your child has a disability and has not attended Jay Nolan Camp previously, we will arrange a meeting with you and your child prior to camp to review the Application and discuss the support needs your child may have while at camp. An appointment can be scheduled to take place during business hours at the Jay Nolan Community Services office, or we can arrange a more convenient time to meet at your home.

HOW TO HELP JAY NOLAN CAMP'S INCLUSIVE ENVIRONMENT

You've chosen to send your child to an inclusive camp for children with and without disabilities to be able to interact with and learn from each other. We're always in search of more children without disabilities to attend our camp. The ratio for each camp session is: 30-35% children with a developmental disability, 65-70% without a disability. At this point, those with an understanding/appreciation of the differences amongst people are the biggest spokespeople on the benefits of sending a child without a disability to a camp like ours. Send an (8-15 year old) sibling, family member, friend, schoolmate, neighbor, etc. our way! More applications can be downloaded at: https://jaynolancamp.org or contact Kim Cade-Henry at (818) 361-6400 x111.

This Camp Application is printed on both sides of the page. Please make sure to fill out the application completely!

Place Child's Recent Photo Here

JAYNOLAN recreational services Summer Camp

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(818) 361-6400 Ext. 111 (Camp Director)
(818) 365-5523 (Fax)
kim@jaynolan.org (E-mail)
http://jaynolancamp.org (Website)

Jay Nolan Camp - Camper Application

Instructions: **We are accredited by the American Camp Association and maintain the standards set by them, in addition to our own. You are required to have a *complete* application, photo, up-to-date immunizations, and a medical exam signed by a licensed physician (listing all current/correct medications). Anything that would be non-applicable, please put 'N/A'. If you need assistance with anything, please let us know.**

2025 Camp Session at Lions Camp at Teresita Pines (Wrightwood, CA)
July 27- August 1, 2025

Child's Name_____
First Last

Address_____
Street

City_____ **State**_____ **Zip**_____

Home Telephone_____ **Date of Birth**_____
MM/DD/YY

Gender:

- ❑ **Male**
- ❑ **Female**

Birthday at Camp?

_____

Age while at camp:

_____

How did you hear about Jay Nolan Camp?

- ❑ **Friend**
- ❑ **Newspaper/Magazine**
- ❑ **Conference**
- ❑ **American Camp Association Directory**
- ❑ **Previous Attendance**
- ❑ **Regional Center**
- ❑ **Online (we'd love to know where you found us!)** _____
- ❑ **Other:**_____

Tee Shirt Size_____
Standard tee shirts are available in Youth S,M,L and Adult S, M, L, XL, 2XL.
Please specify Youth or Adult.

Payment Method:

- ❑ **Check enclosed**
- ❑ **Credit Card**
- ❑ **Regional Center**

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PAYMENT SCHEDULE FOR ALL CAMPERS

Application and payment must be sent together and by the dates that follow to receive the specific rate.

	Dec. 1-Feb. 29	Mar. 1-May 31	June 1- July 1
Campers with a disability	**$1200**	$1250	$1300
Campers without a disability	**$1200**	$1250	$1300

Down Payment - **$300.00** (due with application)

Jay Nolan Community Services, Inc. reserves the right to review and discuss individual needs for support and supervision, which may result in an increased rate.

CANCELLATION POLICY

Payment in full is required at the time of registration. If you need to cancel for any reason, we must receive written notice of cancellation (either mailed or faxed) by **May 31, 2025**. Your registration payment will be refunded less a $50.00 service charge.

Cancellations after that time and 'No-Shows' are non-refundable.

Method of Payment:

_____ Check – Made out to:
Jay Nolan Community Services, Inc.
_____ Cash
_____ Visa
_____ Mastercard
_____ American Express
_____ Online (PayPal)

PLEASE PRINT

Date

Name on Card

Billing Address

City/State/Zip

Phone

Email

AMOUNT:

$_____ Camp Payment

$_____ Donation to help support Jay Nolan Camp

$_____ Total enclosed or to be charged

Credit Card # _____ Exp. date

Authorized Signature

PARENT(S)/ CAREGIVER(S) CONTACT INFORMATION:

Name_____**Relationship**_____
First Last
Address (if different from Child's)_____
Street
City_____**State**_____**Zip**_____

Phone _____**Cell Phone** _____

Alt Cell Phone _____**E-mail**_____

Occupation/Title_____**Employer**_____

Work Phone_____**Ext.**_____

Name_____**Relationship**_____
First Last
Address (if different from Child's)_____
Street
City_____**State**_____**Zip**_____

Phone _____**Cell Phone** _____

Alt Cell Phone _____**E-mail**_____

Occupation/Title_____**Employer**_____

Work Phone_____**Ext.**_____

EMERGENCY CONTACT INFORMATION: (Different than Parent)

Name_____**Relationship**_____
First Last
Address_____
Street
City_____**State**_____**Zip**_____

Phone _____**Cell Phone** _____

Alt Cell Phone _____**E-mail**_____

Occupation/Title_____**Employer**_____

Work Phone_____**Ext.**_____

I give permission to Jay Nolan Community Services, Inc. to allow my child to participate to the best of their ability in a residential camping program including but not limited to these activities,: Archery, Sports & Games, Swimming, Hiking, Rock Climbing Wall, Arts & Crafts, Camp Dance, Talent Show, etc.

Name_____**Relationship**_____
First **Last**

Signature_____**Date**_____

Is there anyone this child would like to bunk with, in the same cabin? (They must be the same gender, and within <u>at least</u> one year of each other). This request will be considered and honored when/if possible. (No guarantees are made.)

Name_____ **Relationship**_____
First **Last**

Name_____ **Relationship**_____
First **Last**

SLEEP PATTERN/ ROUTINE *(Check all that apply)*:

- ❑ **Sleeps throughout the night**
- ❑ **Restless**
- ❑ **Will wake up throughout the night**
- ❑ **Usually uses the bathroom sometime in the night**
- ❑ **Usually goes to bed early (before 8pm)**
- ❑ **Will want to go to bed late (after 10pm)**
- ❑ **Wakes up early (before 7am)**
- ❑ **Will want to wake up late (after 8am)**

Do you have any suggestions to make for a restful night's sleep for your child?

_____
_____

What are your child's favorite foods and/or dietary restrictions (if any)?

FAVORITE FOODS: _____

_____

_____

_____

_____

_____

DIETARY RESTRICTIONS*:

- ❑ **None**
- ❑ **Vegetarian**
- ❑ **Vegan***
- ❑ **Kosher /Halal***
- ❑ **No Dairy**
- ❑ **Gluten Free ***
- ❑ **No Sweets**
- ❑ **Nuts/Beans**

Other dietary restrictions: _____

_____

****Note: Some diets may require that the family send the necessary food/supplements.***

I give permission for the following first aid to be provided by authorized personnel if there is a need (Name brands are listed as examples only). *Check all products that you will permit:*

- ❑ **Sunscreen**
- ❑ **Antibiotic Ointment (Neosporin)**
- ❑ **Anti-Itch Cream/Spray (Caladryl)**
- ❑ **Non-Aspirin Pain Reliever (Tylenol)**
- ❑ **Antiseptic Wash (Betadyne, Peroxide)**
- ❑ **Insect Repellant (Off)**
- ❑ **Non-Prescription Antihistamine (Benadryl)**

Name_____ **Relationship**_____
First **Last**

Signature_____ **Date**_____

DIAGNOSIS:

- ❑ None
- ❑ Autism
- ❑ Asperger Syndrome
- ❑ Cerebral Palsy
- ❑ Down Syndrome
- ❑ Intellectual Disability
- ❑ Seizure Disorder
- ❑ Pica
- ❑ Prader Willi Syndrome
- ❑ ADD/ADHD
- ❑ Bipolar Disorder
- ❑ Chronic Illness:_____ _____
- ❑ Mental Health:_____ _____
- ❑ Other:_____

REQUIRING 1:1 SUPPORT:

- ❑ Does Not Apply
- ❑ Yes
- ❑ No
- ❑ Not Sure

COMMUNICATION SKILLS:

- ❑ Verbal
- ❑ Non-Verbal
- ❑ Limited Verbal Skills
- ❑ Uses Sign Language
- ❑ Uses Facilitated Communication Devices
- ❑ Other:_____

SCHOOL:

Does your child have an IEP for school? Yes___No___
Last grade completed_____
Type of school/program your child participates in:
_____
_____
_____

Regional Center: _____ UCI#_____ Service Coor. Name _____
Service Coor. email _____

SELF-SUFFICIENCY:

Does your child require assistance with the following? *(Check those that apply)*

❑ **Showering** ❑ **Toileting** ❑ **Dressing** ❑ **Eating**

If so, what type of assistance do they require?

❑ **Verbal Prompts** ❑ **Hand-over-hand** ❑ **Complete Assistance**

Please provide additional information:_____
_____
_____
_____
_____
_____
_____
_____
_____

Please select your camper's favorite activities or interest (any that apply):

- ❑ Archery
- ❑ Swimming
- ❑ Group Sports
- ❑ Hiking
- ❑ Rock Climbing Wall
- ❑ Scavenger Hunts
- ❑ Costume Play/Dress Up
- ❑ Acting/Singing/Performing
- ❑ Craft Activities
- ❑ Drawing/Painting
- ❑ Geology/Earth Science
- ❑ Plant/Animal Identification
- ❑ Community Service
- ❑ Activity/Event Planning
- ❑ Advocacy/Social Justice
- ❑ Leadership
- ❑ Environmentalism/Ecology
- ❑ Play in Nature

OVERALL NATURE (BEHAVIOR/ ATTITUDE):
Please make us aware of any potential behaviors to possibly expect....

- ❑ Good-natured
- ❑ Withdrawn/ Shy
- ❑ Self-Injurious
- ❑ Aggressive
- ❑ Wandering
- ❑ Running
- ❑ Tantrums
- ❑ Property Destruction
- ❑ Excessive Verbalization
- ❑ Perseveration
- ❑ Frustration when working on tasks
- ❑ Other: _____

Please explain what we will need to know, about any checked behaviors and their frequency:

_____
_____
_____
_____
_____

HOW SHOULD WE SUPPORT YOUR CHILD DURING CHALLENGING TIMES?

- ❑ Separate from group
- ❑ Reason with
- ❑ Give extra attention
- ❑ Other _____

Please explain what helps your child cool down after challenging moments?
(Music, books, walks, conversation, etc…)

_____
_____

Please explain anything else (or provide more specific information) we need to know in order for your child to have a successful time at Camp (Attach additional pages, if necessary):

_____
_____
_____
_____
_____

This information assists us in applying and for grants/additional funding:

PLEASE CHECK ONE BOX:

	African American	American Indian	Asian	Caucasian	Hispanic	Pacific Islander	Other:
Male							
Female							
Other							

I GIVE MY PERMISSION FOR THE CAMP HEALTH CARE PROVIDER/ AUTHORIZED CAMP STAFF TO ADMINISTER MEDICATION
AND PROVIDE ROUTINE HEALTH CARE (AS MAY BE NECESSARY).

Jay Nolan Community Services (JNCS) isa Covered Entity under HIPAA (the Health Insurance Portability and Accountability Act). to the extent JNCS receives private health/medical information about any of its' clients; JNCS will treat that information as private and comply with applicable privacy laws.

Name_____ **Relationship**_____
First **Last**

Signature_____ **Date**_____

HEALTH AND IMMUNIZATION HISTORY

1. Is Camper covered by Medi-Cal? YES_____NO_____MediCal #_____

2. Is Camper covered by private medical insurance? YES_____NO_____

Medical Insurance_____ Policy #_____

Group #_____Name of Primary Insured_____

ALLERGIES - *List all known.* **REACTION - describe reaction and management of the reaction**

Medication Allergies (list)- include aspirin, penicillin, etc.

_____ _____

_____ _____

Food Allergies (list)- include specific foods, dyes, etc.

_____ _____

_____ _____

Other Allergies (list)- include insect stings, hay fever, asthma, pollen, etc.

_____ _____

_____ _____

GENERAL QUESTIONS: (Explain 'Yes' answers below.)

HAS/DOES THE PARTICPANT:	YES	NO	HAS/DOES THE PARTICIPANT:	YES	NO
Had a recent injury/illness/infectious disease?			Ever had a problem with joints?		
Ever had a chronic/recurring illness/condition?			Have skin problems (itching, rash, acne)?		
Ever been hospitalized?			Have diabetes?		
Ever had surgery?			Have asthma?		
Have frequent colds/headaches?			Had bowel problems (diarrhea, constipation)?		
Had psychiatric/psychological counseling?			Ever had a head injury?		
Had psychiatric/psychological hospitalization?			Have problems with sleepwalking?		
Wear glasses, contacts, or protective eyewear?			If female, have menstrual problems?		
Ever had frequent ear infections?			Have a history of bed-wetting?		
Ever passed out during/after exercise?			Have bladder problems?		
Ever had chest pain during/after exercise?			Ever had an eating disorder?		
Ever had high blood pressure?			Ever had sinus problems?		
Ever had a heart murmur or heart disease?			Other?		
Ever had back problems?			**Been looking forward to camp?**		

Please explain 'Yes' answers:_____

_____

_____

Which of the following has the participant had?

- ❑ **Measles**
- ❑ **Chicken Pox**
- ❑ **Rubella**
- ❑ **Mumps**
- ❑ **Hepatitis A**
- ❑ **Hepatitis B**
- ❑ **Hepatitis C**

TB Mantoux Test
Date of last test_____
Result *(Check)*:
Positive Negative

ATTACH A COPY OF IMMUNIZATION RECORD, OR write in all dates for:

VACCINE:	MO/YR	MO/YR	MO/YR	MO/YR	MO/YR	MO/YR
DTP						
TD (tetanus/diphtheria)						
TETANUS						
POLIO						
MMR						
or Measles						
or Mumps						
or Rubella						
Homophiles influenza B						
Hepatitis B						
Varicella (chicken pox)						

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AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT

____ I, the person named below, consent to medical treatment.

____ I am a parent, guardian or conservator, or person authorized under California or United States Law or by court order, to authorize consent to medical treatment for the person named below.

Name of Person: _____

I authorize Jay Nolan Community Services Inc., any of its employees, agents or contractors to obtain and consent to medical assistance and treatment, including but not limited to: surgery, dental treatment, mental health treatment, and anesthesia, for the person named above. In granting this authorization, I understand as follows:

- That Jay Nolan Community Services Inc. may release information regarding the person's medical history to secure medical assistance or treatment,
- That Jay Nolan Community Services Inc. may provide medical assistance and treatment to the person if other appropriate medical assistance and treatment cannot reasonably be obtained when needed,
- That Jay Nolan Community Services Inc. will make all reasonable efforts to secure medical assistance and treatment with professionally accepted standards for the area where the person is located (not necessarily the place of residence) when treatment is sought,
- That Jay Nolan Community Services Inc. and any of its employees, agents and contractors will make all reasonable efforts to contact me as soon as possible in the event of a medical emergency,
- That Jay Nolan Community Services Inc. carries liability insurance only. I agree that all medical or hospital costs incurred are my sole responsibility.
- That if I have any objections or limitations to treatment, I have them listed below:
  _____
  _____
- That I may terminate this authorization at any time by written notice to the Executive Director of Jay Nolan Community Services. Unless I terminate in this manner, this authorization shall remain in effect for one (1) year after the date signed.

Signature:_____ Date:____/____/____ Relationship:_____

Witness:_____ Date:____/____/____

CONSENTMED, REV2, 12/03

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Public Relations Consent Form

The purpose of this form is to give Jay Nolan Community Services, Inc. permission to use photographs and other likenesses of employees, volunteers, people served, and others who may grant permission for the promotion of the agency's programs, its mission, and general community outreach. Public relations/marketing activities may include, but are not limited to: publication of photographs in newsletters, on the web site, in advertisements, in brochures, on flyers, on display boards, on television, or in video and slide presentations.

NAME_____

I(We), _____, being either of legal age to consent, or the legal parent(s), guardian(s), or conservator(s) of the above named individual who is a minor child or person unable to consent on his or her own behalf, give Jay Nolan Community Services, Inc. (JNCS), its assigns, or successors, the right to use the above named individual's name and any photograph, video, voice recording or any other likeness JNCS has in any media form, now known and hereafter created, for the purpose of promoting JNCS mission, products, services, or programs. JNCS also has the right to substitute the above named individual's voice if it is deemed proper by JNCS.

Furthermore, I(We) agree that such items shall belong to JNCS and remain free and clear of any claim whatsoever on my(our) part or the part of the above named individual.

I(We) understand that I(We) may terminate authorization at any time for any future photographs, video, voice recordings, or other likenesses produced of the above named individual by delivering written notice to the Executive Director of JNCS. However, said termination shall not cover items previously authorized and already in production/use.

_____
(Signature of Consenting Adult/Parent/Guardian)

_____
(Printed Name) (Date)

_____
(Street Address)

_____
(City) (State) (Zip)

_____
(Witness) (Date)

Participant's Name: _____
Print Name

Lions Camp at Teresita Pines & Lions Camp at Wrightwood

Waiver of Liability, Assumption of Risk, and Indemnity Agreement

Waiver: In consideration of being permitted to participate in any way in the Lions Camp at Teresita Pines Rock Climbing Wall (herein after known as "LCTP Rock Wall"), on **7/28/2024** through **8/2/2024** I, for myself, my heirs, personal represen tatives or assigns, **do hereby release, waive, discharge, and covenant not to sue** Lions Camp at Teresita Pines, its officers , employees, volunteers and agents from liability **from any and all claims including the negligence of Lions Camp at Teresita Pines, its officers, employees, volunteers and agents,** resulting in personal injury, accidents or illn esses (including death), and property loss arising from, but not limited to, participation in the LCTP Rock Wall activities.

_____ _____

Signature of Parent/Guardian of Minor Date Signature of Participant Date

Assumption of Risks: Participation in the LCTP Rock Wall activities carries with it certain inherent risks that cannot be eli minated regardless of he care taken to avoid injuries. The specific risks vary from one activity to another, but the risks ran ge from 1) minor injuries such as scratches, bruises, and sprains 2) major injuries such as eye injury or loss of sight, joint o r back injuries, heart attacks, and concussions 3) catastrophic injuries including paralysis and death.

I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent in the activities made possible by the LCTP Rock Wall. I hereby assert that my participation is voluntary and that I knowin gly assume all such risks.

Indemnification and Hold Harmless: I also agree to INDEMNIFY AND HOLD the **Lions Camp at Teresita Pines** HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney' s fees brought as a result of my involvement in the LCTP Rock Wall activities and to reimburse them for anysuch expenses incurred.

Severability: The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is in tended to be as broa and inclusive as is permitted by the law of the State of California and that if any portion thereof is he ld invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Acknowledgment of Understanding: I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, and **understand that I am giving up substantial rights, including my right to sue.** I acknowledge that I am signing the agreement freely and voluntarily, and **intend by my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

_____ _____

Signature of Parent/Guardian of Minor Date Signature of Participant Date

Participant's Age (if minor) _____

Revised 6/2011

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2025 MEDICAL EXAMINATION FORM- PAGE 1

A LICENSED PHYSICIAN MUST COMPLETE THE MEDICAL EXAMINATION FORM.

A MEDICAL EXAMINATION MUST BE PERFORMED WITHIN A YEAR PRIOR TO CAMP ATTENDANCE.

PLEASE COMPLETE BOTH PAGES.

Camper Information

Name:	**Sex:**	**Age:**	**Birthdate:**
Diagnosis or Disability (if applicable):			
BP:	**Height:**	**Weight:**	
Does Camper have a history of seizures? Yes ☐ No ☐			
If yes, specific type:			
Frequency:	**Length:**		
Present Status:	**Date of last seizure:**		

MEDICATIONS (To be administered at Camp)*

If camper is taking herbal/homeopathic medications, vitamins, or over-the-counter medications, they also must be listed. If a psychiatrist prescribes medications, they must complete a form listing medications as well. Attach additional pages, if necessary.

***Please Print Legibly**

Name of prescription medication, vitamins, homeopathic/herbal medications, over-the-counter medications	Dosage	Purpose	Times to be administered (Camp mealtimes/bedtime listed):				
			B-fast 8:30am	Lunch 12:30pm	Dinner 5:30pm	Bedtime 9:00pm	Other ?
1.							
2.							
3.							
4.							
5.							
6.							
7.							

Health Care Providers at camp follow standing orders from our physician consultant, which include over-the-counter medications as needed, such as analgesics, topical ointments, decongestants, and medications for colds, allergies, indigestion, constipation, diarrhea, eye and mouth care, and basic first aid. Are there any concerns with administration of over-the-counter medications and/or treatments?

Yes ☐ No ☐

If yes, explain_____

X_____ **(OVER)** _____

Signature of Physician **Date**

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2025 MEDICAL EXAMINATION FORM – PAGE 2

Camper's Name_____

DESCRIPTION OF JAY NOLAN CAMP FOR PHYSICIAN'S REVIEW

Jay Nolan Camp is an inclusive sleep-away camp that runs 6 days/5 nights each camp session in the mountains of Wrightwood, CA. The elevation is approximately 6,000 ft and the terrain of the campground can be uneven in certain areas. All activities are non-competitive and carefully supervised (including Archery, Sports & Games, Swimming, Hiking, etc.). They are designed to meet the needs of all children, encouraging their participation to the best of their ability. Camp Staff/ On-site Health Care Provider will strictly observe physician recommendations.

RECOMMENDATIONS AND RESTRICTIONS AT CAMP

Treatment to be continued at camp_____

_____

_____

Any medically prescribed meal plan or dietary restrictions_____

_____

_____

Description of any limitation or restrictions at camp_____

_____

_____

Additional information for health care staff at camp_____

_____

_____

HEALTH STATEMENT

I hereby certify that the above camper _____is _____is not in good health and physically able to attend camp. The camper has no evidence of a skin rash or communicable ailment that might endanger the health of other people. The camper has had no recent illnesses with the exception of:_____

Signature of Physician	**Date of Exam**	**Date of Form Completion**

Name of Physician	**Physician's Address**

Name of Medical Agency if Camper attends a Clinic or Hospital	**Telephone No.**	**Fax No.**