's Name:_____ **Patient's DOB**_____

PHYSICIAN'S REPORT

NOTE TO PARENT/GUARDIAN of TEEN KILT: This portion of the report is to be completed by a Physician or NP prior to arrival at camp, OR please provide this information from a previous physical exam completed recently.

Montecito Sequoia Family Camp is in a remote wilderness area at an elevation of 7400' above sea level. The information below is required to provide safe and proper health treatment for our teen KILTs, if needed, during their time with us.

The purpose of this report is to ascertain whether this teen:

1. **Is in good health and can engage in strenuous activity between 7,400' – 8,200' above sea level**
2. **Has a communicable disease that could be conveyed to others**
3. **Has a medical, physical or mental health condition that needs special attention from our camp doctor/nurse/medical mgmt team**
4. **Has special dietary requirements, prescription medications, or limiting physical conditions of which the camp should be aware**

Does this teen (KILT) have any significant:

No Yes
❒ ❒ **Medical Conditions?:**_____
(List condition and any Rx Medications that will be used at camp)

No Yes
❒ ❒ **Physical Conditions?:**_____
(List back, stomach, lung, menstrual issues, etc.)

No Yes
❒ ❒ **Mental Health Conditions?:**_____
(List condition and any Rx Medications/treatments that will be used at camp)

No Yes
❒ ❒ **Communicable Disease?:** _____
(Recent exposure, if any, and if teen is cleared to return to normal activities/social interactions)

No Yes
❒ ❒ **Allergic Conditions?:** _____
(List allergies and any allergy Rx or OTC medications/treatment that will be used at camp)

If more space is needed, please continue below or attach an additional sheet of paper:

List past serious injuries or illnesses (Broken bones, Rheumatic Fever, Pneumonia, Concussions, etc see reverse side of form):

No Yes
❒ ❒ **Does this teen have any Prescription medication(s) to be taken while at camp? If Yes, describe**_____

Medicine/Dosage_____ **Medicine/Dosage**_____
Medicine/Dosage_____

Are IMMUNIZATIONS current?

No Yes ❒ ❒ **Polio**

No Yes ❒ ❒ **Measles**

No Yes ❒ ❒ **Tetanus (Date of last tetanus booster/Tdap: / /)**

No Yes ❒ ❒ **Covid-19 (Primary Series)**

No Yes ❒ ❒ **Covid Fall '23/Winter '24 Vaccine? N / Y**

Yes **Has this teen had Covid in the past year?** ❒ ❒ **Has teen fully recovered from Covid? N / Y**

No Yes **Are you this teen's/patient's regular physician?** ❒ ❒

GENERAL/ADDITIONAL COMMENTS:

Physician's Name (Print)_____ **Phone (_____)**_____

Address_____ **City/Zip**_____

Physician's Signature_____ **Date**_____