Cross Roads Camp and Retreat Center
Health Care Recommendations Must Be Completed by Licensed Medical Provider

You may substitute your physician's generic form for this page if the information provided is comparable.

Camper Full Name:_____ I EXAMINED THIS INDIVIDUAL ON _____(DATE).

*ACA accreditation and the state of NJ specify exams must be within 12 months of camp attendance.

BP _____ Weight _____ Height _____

In my opinion, the above applicant ❑ is ❑ is not able to participate in active camp programs.

The applicant is under the care of a physician for the following conditions_____

Has the participant had any of the following:

___ Measles
___Chicken Pox
___German Measles
___Mumps
___Hepatitis A
___Hepatitis B
___ Hepatitis C

Last TB Mantoux Test
Date _____
Result: __ Pos __ Neg

Vaccine	Mo/Year	Mo/Year	Mo/Year	Mo/Year	Mo/Year
DTP					
TD (tetanus/diphtheria)					
Tetanus					
Polio					
MMR					
Or Measles					
Or Mumps					
Or Rubella					
Haemophilus Influenza B					
Hepatitis B					
Varicella (chicken pox)					

Recommendations and Restrictions at Camp

Treatment to be continued at camp: _____

Medications to be administered at camp (name, dosage, frequency):

Med: _____ Dosage: _____ Frequency: _____

Med: _____ Dosage: _____ Frequency: _____

Med: _____ Dosage: _____ Frequency: _____

Any medically-prescribed meal plan or dietary restrictions: _____

Known allergies: _____

Description of any limitation or restriction on camp activities: _____

Additional information for health care staff at the camp: _____

Signature of Licensed Medical Provider

Signature_____ Print Name _____

Title _____ Date _____

Address_____

Phone (_____)_____ Fax (_____)_____