Last Name	First Name	Birth Date

Upload: to your camp account
OR
Email: forms@campdina.com
OR
Fax: (718) 437-7644
OR
Mail: 5515 New Utrecht Ave.
Brooklyn, NY 11219

Camp Dina Medical Form — Physician's Page

Immunizations:

Immunization Type	Date Basic Series Completed	Most Recent Booster
DTaP / TDaP		
Tetanus		
MMR		
IPV		
HIB		
PCV		
Hepatitis B		
Hepatitis A		
Varicella		
Meningococcal		
H1N1		
Flu Shot		

If any of the immunizations above have not been received, please explain why:

Physical Exam:

Height	Weight	Pulse	Blood Pressure	Hct/Hgb. Test	Urinalysis

Eyes	
Glasses	
Ears	
Nose	
Throat	
Heart	
Neuro	

Lungs	
Abdomen	
Genitalia	
Hernia	
Extremities	
Posture (Spine)	
Skin	

General Appraisal:	Medications:
Allergies:	Recommendations:

I have examined the above patient. Date Examined: _____ In my opinion her condition ☐ **does** / ☐ **does not** allow participation in an active camp program.

Exceptions: _____

Physician's Name: _____ **Physician's Signature:** _____ **Date:** _____ **Phone #:** (____) _____ – _____