abilityTree FIRST COAST
PHYSICIAN STATEMENT

PARENT: Ability Tree First Coast can only accept a camper if this physician's statement is completed, signed, and dated by the doctor.

PHYSICIAN: Thank you for completing this for your patient. For questions, call Joanne Alicea (Director) at 855-288-6735 ext 5.

Camper's Name: _____ Date of Birth: _____

Parent's Name: _____ Doctor's Name: _____

Medical Diagnoses: (Primary)_____ (Secondary)_____

Allergies: _____

This camp is designed for children with developmental, intellectual, & physical disabilities. Do you feel this camper is capable of participating in this camp? Physically? ☐ Yes ☐ No Mentally? ☐ Yes ☐ No

Known limitations: _____

Is camper free from communicable disease? ☐ Yes ☐ No
If no, please explain: _____

Is camper current of all required immunizations? ☐ Yes ☐ No Date of last tetanus shot? _____

Prescriptive Medications:

1. _____ Dosage: _____ Frequency & time: _____

2. _____ Dosage: _____ Frequency & time: _____

3. _____ Dosage: _____ Frequency & time: _____

4. _____ Dosage: _____ Frequency & time: _____

Medical Treatments:

1. _____ Frequency & time: _____

2. _____ Frequency & time: _____

Our office may need to contact you for information. Please provide a telephone number and verify this statement with your office stamp & signature. Thank you.

Office Phone: _____

Date: _____ Physician's Signature: _____