American Youth Foundation
Merrowvista
147 Canaan Road, Ctr. Tuftonboro, NH 03816
603-539-6607 • 603-539-7504 (fax)
www.ayf.com

MERROWVISTA 2020 Health Memorandum

This form verifies the date of child's last physical, and physician recommendations for participation in the camp program.
It must be completed and signed by child's physician.
Return to: Merrowvista; 147 Canaan Road; Ctr. Tuftonboro, NH 03816

Name _____

Program/Session _____

TO EXAMINING PHYSICIAN OR PHYSICIAN EXTENDER:
Merrowvista's Camp programs are physically and mentally strenuous at times, but an individual with normal mental and physical capacity can usually expect to do well in our programs. Examples of activities in our programs include but not limited to swimming, biking, backpacking, sailing, remote camping, traversing rugged terrain, exposure to the natural elements and using challenge courses that may be 50' high or greater. We appreciate your input as to whether there is any need for further evaluation, specific recommendations, or limitation of this participant in our program.

Name of Child _____ **Date of most current/recent physical examination** _____.

Any recent injuries or existing medical condition (chronic or recurring illnesses?) __ No ___Yes if yes, please explain:

_____

Summary of Active Concerns/Restrictions which would preclude child from participating fully in camp program or in remote wilderness backpacking, bicycle or canoe trips (diet, medical, swimming, athletic, psychological) :
None ___ or list below: (use back if necessary)

_____

Health History (Please check all that apply)
_____ Allergies: Drug ___ Food ___ Environmental ___ Bee Stings ___ **Epi-pen required? ___ yes ___ no**
Specify & Describe Reaction: _____

_____ Asthma (type) _____ Well controlled? _____ **Inhaler ? ___ yes ___ no**

If inhalers or epi-pens are prescribed:
Campers prescribed epi-pens or inhalers may be given permission to carry their inhaler or epi-pen with them during camp. Do you have any concerns with this camper carrying their inhaler or epi-pen, their understanding of how to safely posses it, or their ability to self-administer if necessary? ___No ___ Yes

Medications (ALL medication, INCLUDING Psychological)

Medication & Dosage (mg x daily)	Times of admin	Purpose	Special Instructions

Immunizations: ____ copy attached & verified up to date Date of last Tetanus Toxoid Immunization: _____

TB Risk Assessment – Test not necessary if risk deemed low Low Risk _____ High Risk _____ Test results _____ Date:_____

PHYSICIAN SIGNATURE REQUIRED

Physician Name: _____ How long have you known the participant?: _____

Address:_____ Telephone:_____

Physician signature _____Date of Exam _____