



Sidney Albert  
Albany JCC

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## Physician's Medical Report

Completed by Licensed Physician. **The Doctor's own form or School form is fine.**  
Please print using black or blue ink only. **Return forms by June 6, 2025.**

Camper Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Date of last examination \_\_\_\_\_

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant:

- is able to participate in an active camp program
- is able to participate in an active camp program except as noted below
- is not able to participate in an active camp program

Description of any limitation or restriction on camp activities

\_\_\_\_\_

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

\_\_\_\_\_

Current treatment at the time of this report includes

\_\_\_\_\_

Treatment to be continued at camp

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

Any medically-prescribed meal plan or dietary restrictions

\_\_\_\_\_



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Known allergies

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**Immunization History**

***Provide the month and year for each immunization. Starred (\*) immunizations must be current. Copies of immunization forms from health care providers or state or local government are acceptable; please attach to this form.***

Diphtheria, tetanus, pertussis* (DTaP) or (TdaP)
Tetanus booster*(dT) or (TdaP)
Mumps, measles, rubella*(MMR)
Polio*(IPV)
Haemophilus influenzae type B (HIB)
Pneumococcal (PCV)
Hepatitis B
Hepatitis A
Varicella
Had chicken pox
Date:
Meningococcal meningitis (MCV4)
Tuberculosis (TB) test Date: Date: Negative: Positive

**I have reviewed the above camper's health history, and have discussed the camp program with the camper's parent(s)/guardian(s).**

**It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above)**

Name of Licensed Medical Personnel

*(please print)* \_\_\_\_\_

Signature

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Title \_\_\_\_\_

Office Address

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Phone \_\_\_\_\_

Date \_\_\_\_\_