

Medical Form, 2010

South America Snow Sessions LLC

SASS
P.O. Box 267
Guilford, CT 06437
203 458 1632
www.sasnow.com

MEDICAL FORM

Please complete with a licensed physician of the individual who will attend a session at SASS. Return via email or mail to PO BOX address above.

Camper's Name _____

I have examined the above camp applicant within the past two years - YES NO

Date examined - _____

The camper is under the care of a physician for the following condition(s):

Current treatment (include current medications):

Any treatment to be continued at camp:

Any medication to be administered at camp (specific dosages):

Any medically prescribed meal plan or dietary restrictions:

Any allergies (food, drugs, plants, insects, etc.):

Additional health information:

In my opinion _____ is of good physical and mental health and may attend a session at

SASS- YES NO (circle one)

Licensed Physician's Name _____

Licensed Physician's Signature _____

Physician's Information

Address:

City:

State:

Phone:

Date of form completion: _____

* By _____

* Initial if completed by nurse or physician's assistant