

***This medical form must be completed and submitted with the camp application. Camper placement is on a first-come, first-serve basis.***

**PHYSICIAN'S AUTHORIZATION**

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

1. Is this patient mentally retarded, learning disabled or diagnosed with any other developmental disability?  
(Please be Specific) \_\_\_\_\_

2. Does this patient have any physical disabilities related to:

	Disability	Extent
ambulation	_____	_____
hearing	_____	_____
vision	_____	_____
speech	_____	_____
balance &	_____	_____
coordination	_____	_____

3. Does this patient experience any:

- a. Chronic diseases: heart \_\_\_\_\_ diabetes \_\_\_\_\_ other \_\_\_\_\_  
Describe: \_\_\_\_\_  
Resulting limitations: \_\_\_\_\_
- b. Seizures \_\_\_\_\_ degree \_\_\_\_\_ frequency \_\_\_\_\_  
known antecedent \_\_\_\_\_
- c. Frequent colds \_\_\_\_\_ frequency \_\_\_\_\_
- d. Ear infections \_\_\_\_\_ frequency \_\_\_\_\_
- e. Allergies (food restrictions) \_\_\_\_\_
- f. Allergies (Medications) \_\_\_\_\_
- g. Hepatitis \_\_\_\_\_ Type \_\_\_\_\_

4. Has this patient benefited from all recommended immunizations: \_\_\_\_\_

- a. Diphtheria/Tetanus Toxoid (4 doses) Dates: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
- b. Oral Polio Vaccine (3 or more doses) Dates: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
- c. MMR Vaccine (2 doses) Dates: \_\_\_\_\_, \_\_\_\_\_
- d. Hepatitis B (Hep B) ( 3 doses Date:: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
- e. Haemophilus influenza type B (Hib) Date: \_\_\_\_\_
- f. Varicella (Chicken Pox) Date: \_\_\_\_\_

If no, what immunizations are lacking: \_\_\_\_\_

5. Does this patient take medication daily? \_\_\_\_\_

If so, what medication, dosage and time given \_\_\_\_\_  
\_\_\_\_\_

6. I recommend this patient for:

- a. \_\_\_\_\_ full participation in North East Westchester Special Recreation programs
- b. \_\_\_\_\_ participation in North East Westchester Special Recreation programs with the following limitations: \_\_\_\_\_  
\_\_\_\_\_
- c. \_\_\_\_\_ no participation in any North East Westchester Special Recreation programs due to: \_\_\_\_\_  
\_\_\_\_\_

7. Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Return to: North East Westchester Special Recreation, Inc.  
63 Bradhurst Avenue, Hawthorne, New York 10532  
(914) 347-4409

