



2010 Camp Dogwood Physician's Form

To be completed by a physician based on an Annual Physical Examination performed between August 1, 2009 and June 1, 2010.

Name of participant _____ Date of last examination _____

Height _____ Weight _____ Blood Pressure _____

Please circle the correct answer. Does this person have...

History of convulsive disorder	Yes	No
History of back problems	Yes	No
History of ear problems	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Psychiatric diagnosis	Yes	No

If you answered "yes" to any of the above, please explain

Are there any other current treatments (include current medication and instructions) to be continued at camp

Description of prescribed meal plan or dietary restrictions

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Additional health information

Other physicians who treat this child:

Name _____ Office phone: _____

Name _____ Office phone: _____

Immunization History

Give year of last immunization or booster shot for:

_____ DPT Series

_____ Tetanus Booster

_____ Polio

_____ Tuberculin Test

_____ Hepatitis B Series

_____ Mumps/Measles/Rubella

Physician's Signature _____

Date _____

Print physician's name _____

Office Address _____

City _____ State, Zip Code _____

Office phone () _____

When completed, please mail to
AnBryce Foundation
1650 Tysons Boulevard
Suite 900
McLean, VA 22102
Attention: Donna White,
Program Director