



Center for Autism & Related Disabilities New England

HEALTH FORM

Please fill this form out completely and have it signed by your pediatrician.

Name _____

DOB _____

Phone(h) _____

(c) _____

Currently taking medication Y N Explain

Asthma or Allergies Y N Explain

Any reason to not participate in day camp Y N Explain

Physician Recommendation:

_____ **Pass-** physically fit to attend day and/ or overnight camp

_____ **Pass with restrictions** _____

_____ **Fail/Reason** _____

PHYSICIAN SIGNATURE

DATE

PHONE NUMBER _____