

**Camper/ Adult Health  
Form**

Return to: Serbian Orthodox Church  
St. Sava Camp, P.O. Box 965  
Jackson, CA 95642

*(Please type or print)*

Name: \_\_\_\_\_  
*Last First Initial*

Parent/Spouse: \_\_\_\_\_  
*Last First Initial*

Home Phone Number: \_\_\_\_\_ Business Phone Number: \_\_\_\_\_  
*area code/number area code/number*

***In case of emergency when spouse/parents is/are not available, please call:***

Contact Name: \_\_\_\_\_  
*Last First Initial*

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_  
*area code/number*

***To be completed by Physician's Office Only:***

Date of Last Examination: \_\_\_\_\_ *(Must be within past two years)*  
Physician's Name: \_\_\_\_\_  
*(Please print)*  
Address: \_\_\_\_\_  
*street city state zip*  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
*area code/number area code/number*  
**Signature indicates child or adult may attend camp. Please complete reverse.**

***Health Care Recommendations by Licensed Physician***

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

\_\_\_\_\_

Current treatment *(include current medications)* \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion, or concussion \_\_\_\_\_

**Recommendations and Restrictions while at camp:**

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.)* \_\_\_\_\_

Activities to be encouraged or limited \_\_\_\_\_

**Immunizations:**

Date of Last Tetanus Shot: \_\_\_\_\_

Date form Completed: \_\_\_\_\_ \*By: \_\_\_\_\_

*\*If completed by Nurse or physician's assistant*

Licensed Physician's Signature: \_\_\_\_\_