Autism Society of North Carolina
Camp Royall

Office Use Only:
Program ____________
Waitlist ____________
Ex. Date ____________

Doctor's Signature Form

This form is required in addition to the online medical form that you must complete on the registration website. **This form can be filled in by families but MUST be reviewed and signed by the camper's primary care physician. If your camper has multiple doctors please choose the doctor most familiar with their medication needs.**

Camper Information

Camper's Full Name ____

Date of Birth ____/____/____ Age ____ Sex ___

Primary Contact's Name __________________________________

Primary Health Care Facility Information

(Please list primary care, even if a different doctor is signing this form)

Facility Name ____

Name of Primary Physician ____

Address ____

City ______________________________ State __________ Zip ____________________

Telephone __________________ Emergency Phone Number ________________________

Camper's Medical Information

Activity restrictions? ____

____

Date of most recent Tetanus shot: _____________________

Does this camper have seizures? ______Yes _____No ______Grand Mal _____Absence

What protocol do you recommend we follow if a seizure occurs? _____________________________

____

____

Medication Information

Include all **prescription medication and over the counter medications (including supplements & vitamins) that the camper is currently taking.

Please include all the information requested for each medication listed.

Name & strength: ______________________ Dosage: ____________________ Frequency:_______________________ How administered: _____________________ Indication for use: _____________________	Name & strength: ______________________ Dosage: ____________________ Frequency:_______________________ How administered: _____________________ Indication for use: _____________________
Name & strength: ______________________ Dosage: ____________________ Frequency:_______________________ How administered: _____________________ Indication for use: _____________________	Name & strength: ______________________ Dosage: ____________________ Frequency:_______________________ How administered: _____________________ Indication for use: _____________________

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****If you need more space to list medications please make an extra copy of this page as needed.***

Medical Certification

I have examined the camper named on this form, and certify, based on that examination and review of the health and medication information contained on this form, that there is no medical evidence which would preclude the camper's participation in the Autism Society of North Carolina's Camp Royall programs.

Medical Professional's Signature	X________________________________	**Date Signed**	X__________
Medical Professional's Printed Name		**Medical Professionals Address**	

Once signed please either upload to the registration website: https://camproyall.campbrainregistration.com, email to camproyall@autismsociety-nc.org or fax to 919-533-5324.
For questions please contact the Camp Royall office at 919-542-1033.