Newport

Autism Society of NORTH CAROLINA
Social Recreation

Due May 31st

Doctor's Signature Form

Please note: 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. Parents, once you have the signed form please upload to the registration site.** www.asncnewport.campbrainregistration.com

Camper Information

Camper's Full Name _____

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

Primary Contact's Name _____

Primary Health Care Facility Information

Facility Name _____

Name of Primary Physician _____

Address _____

City _____ State _____ Zip _____

Telephone (____)_____ Emergency Phone Number (____)_____

Camper's Medical Information

Any Activity Restrictions:_____

_____

_____

Date of most recent Tetanus shot: _____

Medication Information

****Include both Prescription Medication and Over the Counter Medications that camper will be taking while at Camp. Be sure to include any supplements or vitamins.**

Name/Strength of Drug: _____ Dosage: _____ Frequency:_____ How Administered: _____ Indication for Use: _____	Name/Strength of Drug: _____ Dosage: _____ Frequency:_____ How Administered: _____ Indication for Use: _____
Name/Strength of Drug: _____ Dosage: _____ Frequency:_____ How Administered: _____ Indication for Use: _____	Name/Strength of Drug: _____ Dosage: _____ Frequency:_____ How Administered: _____ Indication for Use: _____

Name/Strength of Drug: ______________________ Dosage: _________________________ Frequency:_____________________________ How Administered: __________________________ Indication for Use: __________________________	Name/Strength of Drug: ______________________ Dosage: _________________________ Frequency:_____________________________ How Administered: __________________________ Indication for Use: __________________________
Name/Strength of Drug: ______________________ Dosage: _________________________ Frequency:_____________________________ How Administered: __________________________ Indication for Use: __________________________	Name/Strength of Drug: ______________________ Dosage: _________________________ Frequency:_____________________________ How Administered: __________________________ Indication for Use: __________________________
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Name/Strength of Drug: ______________________ Dosage: _________________________ Frequency:_____________________________ How Administered: __________________________ Indication for Use: __________________________	Name/Strength of Drug: ______________________ Dosage: _________________________ Frequency:_____________________________ How Administered: __________________________ Indication for Use: __________________________

Please include all of the above information for *each* medication listed.

**If you need more room to list medications please make an extra copy of this page to use 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 NC's Social Recreation Program.

Attending Medical Professional's Signature	**X**______________________________________	**Date** X__________

Attending Medical Professional's Name (please PRINT) ____

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For questions please contact the ASNC Social Recreation Center in Newport
252-658-3020 or SRP_Newport@autismsociety-nc.org