



School/Camp Form Questionnaire

Patients Name: _____ **DOB:** _____

1) Is your child currently taking any medications? Yes___ No___

a. If yes, please list all medications and dosages. Include any over the counter, herbal, vitamins, or sports supplements.

b. Will these medicines be taken at camp or school? Yes___ No___

c. If yes, are there specific times the medications need to be given?

2) Does your child have any allergies to foods or medications? Yes___ No___

a. If yes, please list below.

3) Is there is anything else you would like the camp or school to know about your child?

Yes___ No___

a. If yes, please describe.

4) Does your child wear eyeglasses or contact lenses? Yes_____ No_____

5) Does your child wear braces? Yes_____ No_____