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|  | Program: 2024 Summer High School Program  From: Health Services  Re: Health Exam & Provider Recommendations Form |

## Health Care Recommendations by Licensed Medical Personnel

*Student last name, first name, chosen name (if applicable) Date of Birth*

## Recommendations and Restrictions

Medical Treatment to be continued during the 3-week program:

Medications to be administered during the 3-week program (name, dosage & frequency)

Any medically prescribed meal plan or dietary restrictions?

Known allergies:

Description of any limitation or restriction of physical activities:

Additional information for health care staff:

Signature of licensed medical provider

Printed Name Title

Provider Address (# Street/Apt) City State Zip Phone