THE MARYLAND PEDIATRIC GROUP, L.L.C.

Patient Name: _____ Date of Birth:_____

MPG primary provider:_____

Best telephone number to reach you regarding this form: _____

1. **List current or active medical problems:**

2. **List significant past medical problems:**

3. **List past surgeries with month/year of procedure:**

4. **List any specialists your child has seen in the past year, and reason for visit:**

5. **List all medication your child takes on a daily basis (unless otherwise noted, these medications will be included as medications your child will be taking at camp/school). Please include dosage and time of day your child takes medication. Please include OTC medications taken daily:**

6. **Does your child require a prescription to be sent to your camp's designated pharmacy? If yes, check here ☐ and list dates child will be at camp_____ (There is an additional charge of $20.00 to send prescriptions to designated pharmacies)**

7. **List any allergies (foods, medications, latex, seasonal, etc.)—if none, please write NONE:**

8. **Does your child wear glasses or contact lenses?**

9. **Has your child ever had a concussion and if yes, please list dates.**

10. **Is there any other significant information we need to be aware of? If yes check here_____ (explain details below or on reverse side)**

SIGNATURE_____**DATE**_____

FOR OFFICE USE ONLY:

Date Received: _____
Available on Portal:_____
Portal Pin Given:_____
Fax To: _____
Email To:_____

Fee Paid: _____
Standard form $20_____
Prescription to Camp Pharmacy $20_____
Urgent $40/Will call for Pick Up_____
Family Patient Balance: _____
Provider Performing Last AP: _____
Initials (Staff Intake): _____
Initials (Staff Completing Form): _____