Date: [Insert Date]

To: [Camp Name] Administration
Address: [Camp Address]
Re: Medical Clearance and Accommodation Request

Patient Name: [Child's Full Name]
Date of Birth: [Child's Date of Birth]

To Whom It May Concern,

I am the primary healthcare provider for [Child's Name]. I am writing to provide medical clearance for them to participate in [Camp Name] during the [Year] summer season.

Diagnosis/Condition:
[Insert Diagnosis, e.g., Autism Spectrum Disorder, ADHD, Physical Disability, etc.]

Required Accommodations:
To ensure a safe and successful camp experience, the following accommodations are recommended:

- [Accommodation 1: e.g., Modified physical activity]
- [Accommodation 2: e.g., Quiet space for sensory breaks]
- [Accommodation 3: e.g., Assistance with mealtime or medication]

Medications:
The patient is currently prescribed the following medications to be administered during camp hours:

- [Medication Name], [Dosage], [Time/Frequency]

Emergency Procedures:
In the event of [Specific Symptom/Trigger], staff should [Specific Action].

In my professional opinion, [Child's Name] is cleared to participate in camp activities provided the above accommodations are met. Please contact my office at [Phone Number] if you require further clarification.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]
[Clinic/Hospital Name]