



# Camp Keetov

Washington Hebrew Congregation

Date: \_\_\_\_\_

This is to certify that I have examined \_\_\_\_\_ and find him/her in good health, free of any communicable disease and physically capable of working with young children at Camp Keetov.

Immunizations up to-date \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

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Signature of Physician/Health Care Provider: \_\_\_\_\_

Name of Physician/Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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