



**HEALTH RECORD FORM 2019 – TO BE COMPLETED BY PHYSICIAN**

**NAME OF CHILD:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY, STATE and ZIP CODE:** \_\_\_\_\_

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster does:

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) DPT* Tetanus	1. 2. 3.	1. 2.
Tdap (Anyone 11 & up[ as of July 1)	1. _____ 2. _____ 3. _____ 4. _____	
IPV (4)		
MMR	1. _____ 2. _____	
Varicella (Chicken Pox) <u>Any child born after 1994 must be immunized or proof must be shown that the child had the illness</u>		
Hib (4)	1. _____ 2. _____ 3. _____ 4. _____	
Hepatitis B (3)	1. _____ 2. _____ 3. _____	
Prevnar		
Rota (optional)		
Hep A (optional)		

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
Pulse \_\_\_\_\_

I have examined the above camp applicant within the past year. Date Examined \_\_\_\_\_

The applicant is under the care of a physician for the following condition(s):

\_\_\_\_\_  
\_\_\_\_\_

In my opinion, the above's condition does \_\_\_\_\_ / does not \_\_\_\_\_ preclude his/her participation in an active camp program.

Current treatment (*include current medications*)

\_\_\_\_\_  
\_\_\_\_\_

**Recommendations and Restrictions while at Camp:**

Any treatment to be continued at camp

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Any medication to be administered at camp (*specific dosages*)

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Any medically prescribed meal plan or dietary restrictions

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Any allergies (food, drugs, plants & insects, etc.)

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Additional Health Information

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**Licensed Physician's Stamp** \_\_\_\_\_

**Licensed Physician's Signature** \_\_\_\_\_

Phone \_\_\_\_\_

Area Code/Number

Address \_\_\_\_\_

Street & Number

City

State

Zip Code

Date of Form Completion \_\_\_\_\_ by: \_\_\_\_\_