HEALTH RECORD FORM 2019 – TO BE COMPLETED BY PHYSICIAN

NAME OF STAFF MEMBER: _____

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)Any child born after 1994 must be immunized or proof must be shown that the child had the illness		
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

_____

_____

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

_____

_____

Any medically prescribed meal plan or dietary restrictions

_____

_____

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

_____

_____

Additional Health Information

_____

Licensed Physician's Stamp _____

Licensed Physician's Signature _____

Phone _____
Area Code/Number

Address _____
Street & Number City State Zip Code

Date of Form Completion _____ by: _____