HEALTH RECORD FORM – TO BE COMPLETED BY PHYSICIAN

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 ____

____

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 Signature ____ Phone _______________________________

Area Code/Number

Address ____

Street & Number City State Zip Code

Date of Form Completion _______________________ By ____