



HEALTH RECORD FORM 2018 – 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. _____	
Pevnar		
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: _____