

Camper Name: _____

IMMUNIZATION HISTORY (month and year)

Diphtheria, Tetanus, Pertussis (DTaP or TdaP) 1. _____ 2. _____ 3. _____
4. _____ 5. _____

Most recent Tetanus booster (dT or TdaP) _____

Polio (IPV) 1. _____ 2. _____ 3. _____ 4. _____

Measles, Mumps, Rubella (MMR) _____

Hepatitis B Series 1. _____ 2. _____ 3. _____

Haemophilus Influenzae B (HIB) _____

Other: Pneumococcal (PCV), Hepatitis A, Varicella (chicken pox), Meningococcal meningitis _____

TO BE COMPLETED BY A LICENSED PHYSICIAN:

Date Examined (must be within two years of week attending camp): _____

Height: _____ Weight: _____ Blood Pressure: _____

Most recent TB test (not required, list date): _____

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

Current Medication (s): _____

Allergies to (food, drugs, plants, insects, etc.): _____

Dietary restrictions: _____

Activity restrictions: _____

Medical, Emotional, and Social Health History: _____

Licensed physician's signature: _____

Address: _____

Phone number: _____

Date of form completion: _____ ***by:** _____

*If completed by nurse or physician's assistant

For Camp Use Only

Screening Record

Date Screened _____ Time _____

Meds received _____

Updates/additions to health history noted _____ Yes _____ No _____ None required

Current health needs identified _____

Observational notes _____

Screened by _____

A PHYSICAL IS REQUIRED EVERY 2 YEARS. IF YOU WANT TO USE THIS PHYSICAL FOR NEXT YEAR, PLEASE MAKE A COPY AND KEEP IT FOR NEXT SUMMER. WE DO NOT KEEP FORMS FROM YEAR TO YEAR.