

# IMMUNIZATION HISTORY

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

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (whooping cough) ] DPT Tetanus	1. 2. 3.	1. 2. 3.
Tetanus  Diphtheria ] TD Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given _____ most recent		

### Health Examination by Licensed Physician:

I have examined the above camp applicant within the past two years. Date examined: \_\_\_\_\_

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

This applicant is under the care of a physician for the following condition(s): \_\_\_\_\_

### Current treatment (include current medications):

Explanation of any reported loss of consciousness, convulsions, or concussion: \_\_\_\_\_

Does applicant have epilepsy? Yes \_\_\_\_\_ No \_\_\_\_\_ Does applicant have diabetes? Yes \_\_\_\_\_ No \_\_\_\_\_

### Recommendations and Restrictions While at Camp:

Any treatment to be continued at camp: \_\_\_\_\_

Any medications 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 (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Date of Completion \_\_\_\_\_ \*By \_\_\_\_\_

\*Initial if completed by nurse or physician's assistant.