

◆◆◆◆◆ To be completed by a physician or you may attach a standard form ◆◆◆◆◆

Camper Name   M  F DOB

Vaccines				
	Mo/Yr of Basic Immunization	Mo/Yr of Last Booster		
DPT/DTaP	1		MMR	
	2		Measles	
	3		Mumps	
	4		Rubella	
	5		Hepatitis B	
Td			1	
Tetanus			2	
Varicella			3	
Polio (OPV/IPV)	1		Tuberculin Test	
	2		type	
	3		date	
	4		result	

The exam must be done by a licensed physician and must be performed within 18 months prior to attending camp.

Date of most recent exam:  Height:  Weight:

Allergies (seasonal/environmental/food): .....

Current medications: .....

Reason for taking medications listed: .....

Operations or serious injuries: .....

Physical limitations or restrictions: .....

Is an epi-pen prescribed?  Y  N If yes, reason for use: .....

Provider		
Name:	.....	
Signature:	.....	Date: .....
Address	Street: .....	
City:	State:	Zip Code: .....