MEDICAL FORM

To be completed by licensed physician

Medical History:. A Certificate of Immunization is to be attached. This form must be fully completed before sending to camp.

Provide vaccination dates

Immunizations	**Dose #1**	**Dose #2**	**Dose #3**	**Dose #4**	**Dose #5**
MMR					
Measles					
Polio (OPV OR e-IPV)					
Diphtheria, Tetanus, Toxoids and Pertussis					
Hepatitis B					

Please list any allergies including reaction and treatment (drug, food and environmental):

_____

Please specify any dietary restrictions:

_____

Current medications (MEDICATION ADMINISTRATION RELEASE FORM MUST BE COMPLETED):

_____

Medical history/conditions that may affect the camper's activities while at camp:

_____

Activities encouraged or limited by physician:

_____

TB: In high-risk group? ☐ High: PPD date: _____ Result: _____
☐ Low

Physician's Examination: Blood Pressure: ____/_____ Pulse: _____ Height: _____Weight: _____

Physical Development:

_____

I have completed the above and have examined the individual. In my opinion, the condition of the person listed above does not preclude his/her participation in an active camp program. I have screened the individual for active signs of tuberculosis.

Licensed Physician's Signature: _____Date: _____

Address:_____

Phone: (_____)_____