

Immunization History

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

Vaccines	Date of Basic Immunization	Date of Last Booster
Diphtheria Pertussis (Whooping Cough)] DPT* Tetanus	1 2 3	1 2
or		
Tetanus] TD* Diphtheria		
or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measeles, Rubeola)		
Mumps		
Rubella (German Measles, 3-day Measles)		
Varicella Chicken Pox)		
HIB (Hemophilus Influenza Type B)	1 2 3	
HB (Hepatitis B)	1 2 3	
Other		
Tuberculin Test Given: Y N Date: _____		

Medical Examination—To be filled out by licensed physician. (* Not required by NYS Sanitary Code Subpart 121.1. This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within 7-2) this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Code: V —Satisfactory X —Not Satisfactory (explain) O —Not examined

Hgt. _____ Wt. _____ B.P. _____ Hct. or Hgb. Test _____ Urinalysis _____
 Eyes _____ Lungs _____ . Allergy: (Please specify) _____
 Glasses _____ Abdomen _____ _____
 Ears _____ Hernia _____ _____
 Nose _____ Extremities _____ General Appraisal: _____
 Throat _____ Posture (Spine) _____ _____
 Heart _____ Skin _____ _____
 Genitalia _____

(For Girls and Women)

Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special considerations: _____

Recommendations and restrictions while in camp.

Special diet _____
 Current medications _____ Is parent sending it? _____
 Swimming, diving _____
 Strenuous activity _____
 Other _____

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

Telephone _____
Area/Number
 Date _____

Address _____
 Examining Physician _____ M.D.