

HEALTH HISTORY AND IMMUNIZATION FORM FOR SUMMER CAMP

Camper Name (First-Last) _____ Date of Birth ____/____/____
 Address _____ City _____ State _____ Zip _____
 Parent/Guardian Name _____ Home Phone _____ Bus/Cell Phone _____
 Parent/Guardian Name _____ Home Phone _____ Bus/Cell Phone _____
 Emergency Contact _____ Relationship _____ Home Phone _____ Cell Phone _____
 Emergency Contact _____ Relationship _____ Home Phone _____ Cell Phone _____

Medical Information

Camper's Age _____ Camper's Weight _____ Camper's Height _____ Camper's Gender (circle one) F M
 Family Physician _____ Phone _____
 Family Medical Insurance Co. _____ Policy # _____ Name of Insured Parent _____

Health History (check those that apply and explain below):

- Chicken Pox Mumps Diabetes Seizures Heart Disease / Defect Asthma
 Measles Mononucleosis Bleeding Disorders Epilepsy Musculoskeletal Disorder Hay Fever
 German Measles Ear Infections Hypertension Allergies (Common allergies include foods, nuts, drugs, insect stings, plants/pollen, and animals. Please explain below.)

Explain: _____

Indicate and explain health conditions below.

- Operations/Serious injuries Chronic or recurring illness Dietary restriction Learning difficulties Physical, social or special emotional needs

Explain: _____

Minimum immunization requirements: 3 doses of DTP and/or Td vaccine; 3 doses of polio; 2 doses of live measles vaccine; 1 dose of live mumps vaccine; and 1 dose of live Rubella vaccine. Additional dose of MMR required prior to 7th grade. Td booster required every 10 years.

Immunizations - Must Include Dates

Primary Series Dates

Date of Last Booster


Immunizations - Must Include Dates	Primary Series Dates	Date of Last Booster
DTP or Td (Diphtheria, Tetanus, Pertussis of Tet Diphtheria)		
Polio		
Measles (red or hard measles)		
Rubella (3-day or German measles)		
Mumps		
Influenza Type B		
Varicella (Chicken Pox)		
Other (Hepatitis B)		

Special Conditions to be watched for (i.e. fainting, menstrual cramps, etc.) _____

This health history is correct so far as I know, and the person described has permission to engage in all camp activities except as noted. I give permission: 1) to the medical personnel selected by the Camp Director to hospitalize, secure proper treatment such as anesthesia or surgery, and to provide or arrange necessary transportation for myself/or my child; and 2) for the Camp Health Supervisor to treat minor injuries or illness as directed by orders of a licensed physician; administer prescription medication brought to camp in its original container, labeled with child's name, physician's name and dosage; and/or administer over-the-counter medication unless otherwise specified below.

List all over-the-counter medications that **may not** be administered to your child: _____

Medications Administered: (ALL medications including prescription or over-the-counter)

MUST CHECK ONE  My child takes NO medication on a routine basis OR My child takes medication as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med # 2 _____ Dosage _____ Specific times taken each day _____

Reason for Taking _____

Signature of Parent/Guardian _____ **Date** _____