

# Medical Information

**PART 1**

Gender M  F

Camp Enrolled in \_\_\_\_\_

Camper's Full Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ Month / Day / Year

Home Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Doctor's Name & Phone # \_\_\_\_\_

**PART 2**

Please indicate any condition which might effect this child's performance at summer camp or any condition of which the staff should be aware: medical treatments, special requirements as to diet, rest, allergies, avoidance of certain activities or other care.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Recommendations:

\_\_\_\_\_  
 \_\_\_\_\_

**PART 3**

Child's Name \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Measles _____                 | <input type="checkbox"/> Mumps _____         | <input type="checkbox"/> Rheumatic Fever _____    | <input type="checkbox"/> Epilepsy _____      |
| <input type="checkbox"/> Chicken Pox _____             | <input type="checkbox"/> Scarlet Fever _____ | <input type="checkbox"/> Otitis Media _____       | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Whooping Cough _____          | <input type="checkbox"/> Poliomyelitis _____ | <input type="checkbox"/> Convulsions _____        | <input type="checkbox"/> Pneumonia _____     |
| <input type="checkbox"/> Hernia _____                  | <input type="checkbox"/> Diabetes _____      | <input type="checkbox"/> Physical Handicaps _____ | <input type="checkbox"/> Allergies _____     |
| <input type="checkbox"/> Developmental Challenge _____ |  |   |  |

**PART 4**

VACCINE TYPE	DISEASE M/D/Y	1ST DOSE M/D/Y	2ND DOSE M/D/Y	3RD DOSE M/D/Y	4TH DOSE M/D/Y	5TH DOSE M/D/Y	M/D/Y
DIPHTHERIA, TETANUS, PERTUSSIS (DTP) If Td, DtaP or DT* indicate in corner box							
POLIO ORAL POLIO VACCINE (OPV) If Salk Vaccine, indicate IPV in corner box							
MEASLES, MUMPS, RUBELLA (MMR)							
MEASLES					Measles Serology	Date:	
RUBELLA					Rubella Serology	Date:	
MUMPS					Mumps Serology	Date:	
HAEMOPHILUS B (HIB)**							
HEPATITIS B***							
OTHER, SPECIFY							

**PART 5**

**Parent's Authorization:** Medical history is correct and complete. My child is current regarding all required children's immunizations. I know of no reason to restrict campers activities and give permission for participation in all activities, except as specifically noted, herein. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure treatment for and to order injections, anesthesia or surgery for my child as named above. Continuous efforts will be made to contact the parent/guardian.

The above named child has been given a routine medical examination and has been found to be free of infectious or contagious diseases by our Pediatrician.

Signature of Parent / Date \_\_\_\_\_

Signature of Parent / Date \_\_\_\_\_

