

Camper's Name

Session

Birth Date

Immunization Form

HEALTH FORM 

Please complete this form. Upload, fax or mail by April 30.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Latest
DTaP or Tdap Diphtheria, tetanus, pertussis	<input type="text"/> mm/yyyy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Tetanus, Pertussis booster						<input type="text"/>
MMR Mumps, measles, rubella	<input type="text"/>	<input type="text"/>				<input type="text"/>
IPV Polio	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
HIB Haemophilus influenzae type B	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
PCV Pneumococcal	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Hepatitis B	<input type="text"/>	<input type="text"/>	<input type="text"/>			
Hepatitis A	<input type="text"/>	<input type="text"/>				
Chicken Pox Varicella	<input type="text"/>	<input type="text"/>				
MCV4 Meningococcal meningitis	<input type="text"/>					
H1N1 Swine flu	<input type="text"/>	<input type="text"/>				
Flu shot						<input type="text"/>

If any of the immunizations listed above have not been received, please explain why. Use a second sheet if necessary.

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Parent Authorization & Insurance Cards

HEALTH FORM 

Place your Medical Insurance card here
FACE UP
 &
 Photocopy

Place your Prescription card here
FACE UP
 &
 Photocopy

Place your Medical Insurance card here
FACE DOWN
 &
 Photocopy

Place your Prescription card here
FACE DOWN
 &
 Photocopy

Authorization Statement

Please read the following statement carefully before signing below.

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted. It is my intention that the camp be treated as acting in loco parentis if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. I understand that part of the Camp experience involves activities and group living arrangements and interactions that may be new to my child, and that they come with certain risks and uncertainties beyond what my child may be used to dealing with at home. I am aware of these risks, and I am assuming them on behalf of my child. I realize that no environment is risk-free, and so I have instructed my child on the importance of abiding by the Camp's rules, and my child and I both agree that he or she is familiar with these rules and will obey them.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

Signature	Date
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Physician's Examination

HEALTH FORM 

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activity.

Height

Weight

Pulse

Blood Pressure

Hct/Hgb Test (if appropriate)

Urinalysis (if appropriate)

Please rate the following:

V – Satisfactory
X – Not satisfactory
O – Not examined

Eyes

Ears

Nose

Throat

Lungs

Heart

Abdomen

Genitalia

Hernia

Extremities Posture

Skin

Neuro

General Appraisal

Please address any concerns from above.

Medications

Please list any medications the applicant is currently taking.

Allergies

Please list any allergies the applicant may have.

Immunizations

Date of last tetanus shot

Are immunizations up to date?

Yes

No

Current Medical Problems and Treatments

Use a second sheet if needed.

Recommendations

List restrictions on the applicant at camp.

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

I examined the applicant today

Yes

No

If no, date of examination

Name of Doctor

Signature

Date

Contact Information