

PARTICIPANT MEDICAL INFORMATION

Please attach a copy of the camper's Immunization records (preferred) or complete dates of the following immunizations.

DPT Series: Date 1 _____ Date 2 _____ Date 3 _____ Booster _____
Tetanus Booster _____ Polio OPV _____ Booster _____ DTap _____
Haemophilis Influenza Type B _____ Hepatitis B _____ Varicella (Chicken Pox) _____
MMR Vaccination and Booster _____

Medical Information:

Date of last physical exam _____ (must have been within the last year)

Name of Physician _____ Address _____

Telephone Number of Physician (____) _____

Family History: (list all familial diseases, such as Diabetes, Tuberculosis, Epilepsy, etc.)

Existing Communicable Diseases: _____

My son is allowed to use sun screen. _____ (Parent Signature)

Personal History: (Check those of the following diseases or conditions that the camper has had)

- ___allergy injections ___anemia ___bronchitis ___epilepsy
___chicken pox ___chronic intestinal prob. ___diabetes ___hives
___congenital or heart prob. ___diphtheria ___eczema ___hepatitis
___emotional disorder ___frequent colds ___sore throats ___hay fever
___infectious jaundice ___kidney disease ___malaria ___malignancy
___measles ___Rubeola(English/Red) ___Rubella(German) ___mumps
___mononucleosis ___orthapedic problems ___otitis media ___tonsillitis
___hearing impairment ___poliomyelitis ___pneumonia ___sinusitis
___psychiatric disease ___rheumatic fever ___scarlet fever ___TB contact
___rheumatoid arthritis ___seizure disorder ___speech defect
___tuberculosis ___whooping cough ___NONE OF THE ABOVE

Severe injuries/operations (with dates) _____

Any known allergies _____

Medical Problems _____

Physician Recommendations/Restrictions (To Be Completed By Physician)

Diet: _____

Medications: _____

Physical Activity: _____

Physician Signature: _____ Date _____