

Mohawk Summer Rec Program
Health Maintenance Form

THE MOHAWK SUMMER REC PROGRAM MUST RECEIVE THIS FORM BEFORE YOUR CHILD MAY ATTEND THE PROGRAM.

Name _____ DOB _____ Age _____ Sex _____

PHYSICAL EXAM FINDINGS: Date of Physical Exam _____

BP _____ / _____ P _____ Height _____ Weight _____

Physical Development: _____ WNL _____ AB

Nutritional Status: _____ WNL _____ AB

Skin: _____ WNL _____ AB Eyes: _____ WNL _____ AB

Ears: _____ WNL _____ AB Nose: _____ WNL _____ AB

Mouth: _____ WNL _____ AB Teeth: _____ WNL _____ AB

Neck: _____ WNL _____ AB Throat: _____ WNL _____ AB

Heart: _____ WNL _____ AB

Abdomen: _____ WNL _____ AB Spine: _____ WNL _____ AB

IMMUNIZATIONS: (Please record the date: day, month, year)

DTP1 _____ DTP2 _____ DTP3 _____ DTP4 _____ DTP5 _____ TD _____

MMR1 _____ MMR2 _____ HEPB1 _____ HEPB2 _____ HEPB3 _____

IPV/OPV1 _____ IPV/OPV2 _____ IPV/OPV3 _____ IPV/OPV4 _____

Varicella: Vaccination _____ Disease _____

ALLERGIES: _____

ACUTE/CHRONIC MEDICAL CONDITIONS: _____

DAILY/PRN MEDICATIONS: (Such as for asthma, allergic reactions, etc) _____

MD Signature

Date

***COMPLETE ATTACHED MEDICATION FORM IF NEEDED

Mail form to Mohawk Summer Rec Program, 33 Mechanic St., Shelburne Falls, MA 01370 Attn: Mary Johansmeyer