PARTICIPANT MEDICAL INFORMATION

Please attach a copy of the camper’s Immunization records (preferred) or complete dates of the following immunizations (required by the NY State Department of Health).

DTapSeries: Date 1\_\_\_\_\_\_\_ Date 2 \_\_\_\_\_\_\_ Date 3\_\_\_\_\_\_\_ Date 4\_\_\_\_\_\_\_Date 5 \_\_\_\_\_\_\_

Tdap Booster\_\_\_\_\_\_\_ Polio OPV Date 1 \_\_\_\_\_\_\_Date 2\_\_\_\_Date 3\_\_\_\_\_ Booster \_\_\_\_\_\_\_

Meningococcal\_\_\_\_\_\_\_\_\_\_HIB \_\_\_\_\_\_\_

Hepatitis B Date 1\_\_\_\_\_\_\_Date 2\_\_\_\_\_ Date 3\_\_\_\_\_ Varicella (Chicken Pox) \_\_\_\_\_\_\_

MMR Vaccination and Booster Date 1\_\_\_\_\_\_\_\_Date 2\_\_\_\_\_\_

Pneumococcal Vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 daughter 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 \_\_\_tonsillitus

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