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).

TDAP \_\_\_\_\_\_\_ DTaP/DTP \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_ Varicella (chickenpox) \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Polio \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_or 3 doses if doses received t age 4 or older

MMR \_\_\_\_\_\_ \_\_\_\_\_\_ Hep B \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_ Meningitis \_\_\_\_\_\_ (grade 7,8 or 9)

Tetanus Booster \_\_\_\_\_ Haemophilis Influenza Type B \_\_\_\_\_\_

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/son is allowed to use sunscreen. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent Signature)

Personal History: (Check those of the following disease 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 \_\_\_ orthopedic 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physical Activity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_