



CAMPER HEALTH FORM SUPPLEMENT

To Be Completed by Physician/Pediatrician

**Physician/Pediatrician may substitute with his/her own form/Universal Child Health Record*

Camp Name: _____

I examined _____ on _____ and in my opinion, he/she
(camper's name) (date)

is is not able to participate in an active camp program.

Recommendations and Restrictions at Camp:

Treatment to be continued at camp:

Medications to be administered at camp (name, dosage, frequency):

****Please note that parent/guardian must fill out "Authorization to Administer Medication" form if medication is to be administered to your child at camp.**

Known Allergies (please describe the reaction and management of the allergy):

Description of any limitation or restriction on camp activities:

Record of Immunizations:

(please fill in or attach record)

Vaccine:	Dates:					
	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	___	___	___	___	___	___
TD (tetanus/diphtheria)	___	___	___	___	___	___
Polio	___	___	___	___	___	___
MMR	___	___				
or Measles	___	___				
or Mumps	___	___				
or Rubella	___	___				
Haemophilus Influenza B	___	___	___	___		
Hepatitis B	___	___	___			
Varicella (chicken pox)	___	___				

Is the child exempt from any immunizations?

YES NO

If YES, which ones?

Signature of licensed medical personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date _____