Physical Examination: To be completed by Doctor ***(Directions:*** *The Health Exam (**within 18 months for of the last day of the camper's session**) if the patient has had a physical exam within the time period noted above, a new physical is not required)*

Name of Camper: ____

Height ____________________________ Weight ____________________________ Blood Pressure ______________________

Immunization History (Check all applicable giving month and year) – *An immunization record can be attached*

Immunization							Minimum Shots required by MA
Measles, Mumps, Rubella (MMR)	1	2				Booster:	2
or Measles	1	2				Booster:	2
or Mumps	1	2				Booster:	2
or Rubella	1	2				Booster:	2
Polio	1	2	3	4	5	Booster:	IPV or OPV -3 or mix of IPV and OPV-4
Diphtheria and Tetanus Toxoids and Pertussis DTaP/DTP/DT	1	2	3	4		Booster:	3 - PLUS TD booster required for all over the age of 7
Hepatitis B	1	2	3			Booster:	3
Varicella	1	2					2 recommended
Haemophilus influenza b (HIB)						Booster:	
Other						Booster:	

Please list any allergies or dietary restrictions:

Is the individual under the care of a physician for any condition or impairment which may affect the individual's activities while attending the camp? *Please explain* (include treatment and current medications)

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp

Any medication to be administered at camp (please complete medication administration form for each)

Please describe any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or consideration while at camp

Please list any camp activities from which the individual should be exempted for health reasons

Medical Information pertinent to routine care and emergencies.

Health Care Recommendations by Licensed Physician

In my opinion, the above condition ☐ **does** ☐ **does not** preclude his/her participation in an active camp program.
I have examined the person herein described and have reviewed her/his health history within the last 18 months. It is my opinion that she/he is physically able to engage in any camp activity except as noted above.

Examining Physician (Please Print):_________________________________ Date Physical Performed:___________

Physician's Signature:____ Date Signed:_____________________

Address:____

Phone Number with Area Code:____

Doctor