PARTICIPANT MEDICAL INFORMATION

Please attach a copy of the camper's Immunization records (preferred) or complete dates of the following immunizations.

DPT Series: Date 1_____ Date 2 _____ Date 3_____ Booster _____
Tetanus Booster_____ Polio OPV _____ Booster _____ DTap _____
Haemophilis Influenza Type B _____ Hepatitis B _____ Varicella (Chicken Pox) _____
MMR Vaccination and Booster_____

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 son 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_____