Medical Form

Child

First Name (print)

Last Name (print)

Date of Birth (mm/dd/yyyy)

Gender
❏ Male   ❏ Female

Parent/Guardian

First Name (print)

Last Name (print)

Health

Food Allergies

Drug Allergies

Immunization Dates (mm/dd/yyyy)

DPT

Sabin Polio	Measles	Mumps	Rubella

Hepatitis B	Varivax	MMR	HIB

Hayfever	Asthma	Tuberculin Test (within 12 months)

Is there any physical, emotional or health problem of which the camp should be informed?

Is the child currently under medical treatment? If yes, please specify.

Please give any information you may have that may be of use to the camp.

Physician

Signature (sign)

Date of Physical Examination (mm/dd/yyyy)

Address

City	State	Zip	Phone