**Winding Trails Summer Day Camp**

**Health Exam Form**

This form (or equivalent form) is to be completed with an exam date of within three years of attendance.

Camper Name _____ Date of Birth _____

## Immunization History

Required immunizations must be determined locally. Please record the date (month and year) of basic immunization and most recent booster doses.

| Vaccines | Year of Basic Immunization | Year of Last Booster |
|---|---|---|
| DTP | | |
| DTP/Hib | | |
| DTaP | | |
| DT/Td | | |
| OPV | | |
| IPV | | |
| MMR | | |
| Measles | | |
| Mumps | | |
| Rubella | | |
| HIB | | |
| Hep B | | |
| Varicella | | |
| PCV | | |
| Meningitis | | |

## Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the past two years. **Date Examined:** _____

Please check one.

This camper ☐ may ☐ may not participate fully in the camp program.

Height _____ Weight _____ Blood Pressure _____

The applicant is under the care of a physician for the following condition(s):

_____

Current treatment (include current medications):

_____

Explanation of any reported loss of consciousness, convulsion or concussion:

_____

Does applicant have epilepsy? ☐ Yes ☐ No Does applicant have diabetes? ☐ Yes ☐ No

## Recommendations and Restrictions While at Camp

Any treatment to be continued at camp:

_____

Any medications to be administered at camp (specific dosages):

_____

Any medically prescribed meal plan or dietary restrictions:

_____

Any allergies (food, drug, plants, insects, etc.):

_____

Additional Health Information:

_____

**Licensed Physician's Signature** _____

Address _____ Phone _____

Street & Number City State Zip Area/Number

Date of Form Completion _____ *By _____

* Initial if completed by nurse or physician's assistant