O BE COMPLETED BY YOUR HEALTH CARE PROVIDER

MUNIZATION HISTORY (Please booster according to ACIP guidelines)

. TETANUS-DIPHTHERIA — month / day / year
Completed primary series of tetanus-diphtheria immunizations..... ____/____/____

. M.M.R. (MEASLES, MUMPS, RUBELLA) if given instead of individual immunizations
1. ☐ Dose 1 – Immunized on or after first Birthday..... ____/____/____
2. ☐ Dose 2 – Immunized at five years or later..... ____/____/____

. MEASLES
1. ☐ Dose 1 – Immunized with live measles vaccine on or after the first birthday..... ____/____/____
2. ☐ Dose 2 – Immunized at least one month after Dose 1 (Recommended by the State..... ____/____/____
Department of Health, the ACHA, CDC, AAFP and AAP and required by SHU)

. RUBELLA
☐ Immunized with vaccine on or after first birthday..... ____/____/____

. MUMPS (check appropriate box)
1. ☐ Had disease; confirmed by office record..... ____/____/____
2. ☐ Immunized with vaccine on or after first birthday..... ____/____/____

. POLIO (check appropriate box) Type of Vaccine: ☐ Oral ☐ Inactivated ☐ E-IPV
Complete primary series of Polio Immunization..... ____/____/____

. TUBERCULOSIS PPD Applied_____ (must be within past year) ☐ Positive ☐ Negative
If PPD positive, please note chest x-ray date and results as well as INH dates under remarks below

Any History of reaction to food, serum, drugs, or medication? ☐ Yes ☐ NO
Explain_____

SEX_____ AGE_____ HEIGHT_____ WEIGHT_____ BP_____ PULSE_____ RESP_____
VISION: Uncorrected – Right 20 / _____ Left 20 / _____ With glasses / contacts - Right 20 / _____ Left 20 / _____
HEARING: Right Normal - ☐ Yes ☐ No Left Normal - ☐ Yes ☐ No Impairment_____

	SYSTEM	SATISFACTORY	UNSATISFACTORY	DESCRIBE ABNORMALITY
1	Skin, Lymphatics			
2	Eyes			
3	Ears			
4	Nose, Throat			
5	Neck, Thyroid			
6	Chest, Breasts, Lungs			
7	Heart Rate / Rhythm			
8	Heart Murmur (describe)			
9	Abdomen, Liver, Kidneys, Spleen			
10	Hernia			
11	Genitalia			
12	Pelvic (if indicated)			
13	Rectal (if indicated)			
14	Extremities, Back, Spine			
15	Joints			
16	Neurological			

The following abnormalities should be noted:_____

The applicant ☐ DOES ☐ DOES NOT have a history of emotional, psychological, or psychiatric disturbance
☐ Applicant may participate in camp activities: ☐ Without restriction ☐ With the following restriction_____
☐ Applicant should not participate in sports. Reason for limiting activity_____

HEALTH CARE PROVIDER (Please Print) NAME_____ PHONE_____

ADDRESS_____ SIGNATURE_____