

Gloucester Museum School Project Adventure Summer Camp Immunization Form

**Camper's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

The above patient was examined on \_\_\_\_\_. The patient's health history and immunization records were reviewed.

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ BP: \_\_\_\_\_ Vision: Left \_\_\_\_\_ Right \_\_\_\_\_

Color \_\_\_\_\_ Postural Screen \_\_\_\_\_

Allergies: \_\_\_\_\_

Chronic Medical Problems: \_\_\_\_\_

Medications/Treatments: \_\_\_\_\_

Dietary Restrictions: \_\_\_\_\_

I SEE NO REASON(S) TO RESTRICT FULL PARTICIPATION IN CAMP ACTIVITIES.

Physician's Name (Printed): \_\_\_\_\_ Phone #: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address of Practice: \_\_\_\_\_

PARENTS: I CERTIFY THAT MY CHILD HAS NOT INCURRED ANY SIGNIFICANT HEALTH PROBLEM(S) SINCE THE DATE OF THE ABOVE PHYSICAL EXAM.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Immunization History**

DPT/DTaP/Td	OPV/IPV	HIB	Hept B	LEAD Date/Result
1.	1.	1.	1.	
2.	2.	2.	2.	
3.	3.	3.	3.	
4.	4.	4.		
5.	5.	Varivax (chicken pox)	Influenza Vaccine	TB Risk Screen
	.MMR	1.	1.	
	1	2.	2..	
Other Immunizations	2.	Chicken Pox	3.	
		1.	4.	

Physician: please fill out completely and sign – use other side of form if need be for further information