BOYS & GIRLS CLUBS
OF MERIDEN

Summer Camps

15 Lincoln St Meriden, CT 06451 203-235-8185 Fax: 203-686-1029

Date of Exam:_____

YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS AND STAFF

Name:_____ Phone #_____ D.O.B._____

Address:_____

Identify any known medical or emotional illness or disorder that would currently pose a risk to others or which would currently affect the individual's functional ability to participate safely:

_____

_____

Medical information pertinent to routine care and emergencies:

_____

_____

Is this individual taking prescription medication? ☐YES ☐NO

If yes, indicate prescription:_____

Does the individual have allergies? ☐YES ☐NO

Explain:_____

Is the individual on a special diet? ☐YES ☐NO

Explain:_____

IMMUNIZATION RECORD: (Month, Day, Year for each dose)

IMMUNIZATION	DATE					IMMUNIZATION	DATE
	1st DOSE	2nd DOSE	3rd DOSE	4th DOSE	5th DOSE		
DTP/DTaP/DT						MMR (I st Dose)	
OPV/IPV						MEASLES (2nd Dose)	
Hib (HAEMOPHILUS INFLUENZA TYPE B)						VARICELLA (Chicken Pox) (Reccommended)	
HEPATITAS B						OTHER (Specify)	

Are there medical contraindications to immunization? ☐Yes ☐No

If yes, specify the vaccine(s) and indicate the contraindicafions specified in the vaccine manufacturers' package insert that applies.

_____

Does this individual have laboratory confirmed proof of immunity to natural infection? ☐Yes ☐No

If yes, please explain and attach laboratory report:_____

Is this individual current or in progress with immunizations according to the schedule adopted by the Commissioner of Public Health? ☐Yes ☐No Next Appointment for Immunization is scheduled _____

Month/Day/Year

Medical Care Provider (Name, Address, Telephone#): Signature of MD, APRN or PA:_____

Date Form Signed:_____