Camper's Name: _____

Camp(s) Attending: _____

Health Examination Form (during the past 12 months prior to camper's attendance at camp)

This side of the form is for physician's use only

YOU MAY SUBMIT A PRINT OUT FROM YOUR DOCTOR INSTEAD OF THIS FORM, but please put this as your cover sheet if it has a bar code on it to fax.

Written verification from licensed medical personnel may be used instead of filling out this Health Form. We need the following: 1. COMPLETE immunization record (ALL dates listed) from public school or physician immunization records, 2. report of physical examination conducted during the past 12 months prior to camper's attendance at camp, 3. any current or on-going treatment or medications, and 4.any condition requiring restriction of participation in the camp program.

Immunization Record

Vaccines	Month/Year	Month/Year	Month/Year	Month/Year	Doses/Boosters
D.T.P. (4 doses)	1. _____	2. _____	3. _____	4. _____	Booster: _____
Polio (3 doses or more)	1. _____	2. _____	3. _____		Booster: _____
M.M.R. (2 doses, except 1 dose gr.6)	1. _____	2. _____			
Tetanus	1. _____				
Tuberculin Test	Type _____	Year _____	Results _____		
Hepatitis B*	1. _____	2. _____	3. _____		

*Effective January 1, 1999, for all children born on or after January 1, 1992, three doses of Hepatitis B vaccine are required.

Date of Examination: ____/____/____ Height: ____ft. _____in. Weight:_____ B.P.:_____

Appearance--Nutrition:_____

Without Glasses: Eyes (R) 20/_____ (L) 20/_____ Color Vision: _____ Ears: _____

With Glasses: Eyes (R) 20/_____ (L) 20/_____ Hearing: (R) _____ (L) _____

Rate the Following Using:

Satisfactory (S) Unsatisfactory (U) Not Examined (N)

_____ Nose	_____ Genitalia	_____ Throat	_____ Lungs
_____ Teeth	_____ Skin	_____ Heart	_____ Musculoskeletal
_____ Abdomen	_____ General physical and emotional status		

Has the camper had the chicken pox or the chicken pox vaccine? ___ Yes ___ No Date of Vaccine _____

Targeted TB Skin Testing: ☐ Med-to-High Risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
Date of PPD: _____; Results: _____mm.
Referred for evaluation to: _____ ☐ Low Risk (no PPD done)

Illnesses & Injuries (Chronic or Recurring Illness. Check those that apply and give appropriate dates)
☐ Ear Infection ☐ Bleeding/Clotting Disorders ☐ Hypertension ☐ Asthma ☐ Seizures ☐ ADHD ☐ Frequent Sore Throats ☐ Heart Defect/Disease ☐ Musculoskeletal Disorders ☐ Diabetes ☐ Constipation ☐ Bed Wetting ☐ Sleep Walking ☐ Motion Sickness ☐ Kidney Trouble ☐ Eating Disorder ☐ Sinusitis
☐ Other (specify):_____
Were any medical problems noted? _____

Physician's Authorization: This person is in satisfactory condition and may engage in all usual activities except as noted. I certify that the above information, including the immunization record, is current and complete.

Licensed Physician's Printed Name: _____ Phone ( ) _____

Street Address: _____ City_____ State_____ Zip_____

Licensed Physician's Signature: _____

Return to: GSEMA Summer Camp, 111 East Grove Street, Middleboro, MA 02346