New England Sports Camps &
Alfond Youth & Community Center

CAMPER HEALTH HISTORY FORM

Mandatory for Adventure, Excursion & New England Sports Campers.

Camper Name _____ **DOB** _____

Immunization History Provide the month and year for immunizations. Starred (*) immunizations must be current. **Copies of immunization forms from health-care providers or state or local government are acceptable, please attach to this form.**

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis* (DTaP) or (TdaP)						
Tetanus booster * (dT) or (TDaP)						
Mumps, measles, rubella * (MMR)						
Polio * (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCB)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) _____ Had chicken pox _____ Date						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date	Negative	Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

_____ Signature of Parent/Guardian

_____ Date

_____ Relationship to Camper

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THIS PAGE IS TO BE COMPLETED BY A PHYSICIAN

Copies of a recent sports/camp physical form from health-care providers are accepted in place of this page.

Physical Exam Completed Today: ____ Yes ____ No (If no, date of last physical ____/____/____/)

Weight _____ lbs Height _____ ft _____ in Blood Pressure _____/_____

Allergies ____ no known allergies

If the child has allergies, please select from the options below, list the specifics and describe the reactions:

____ Food Allergies

____ Medicine

____ The environment (insect stings, hay fever, etc.)

____ Other

Diet & Nutrition ____ This camper eats a regular diet
____ has a medically prescribed meal plan or dietary restrictions (describe below):

This camper is undergoing treatment at this time for the following conditions (describe below):
___ OR None

Medication ____ no daily medications ____ Will take the following medication(s) while at camp
(please list name, dose, frequency - describe below)

Other treatments/therapies to be continued at camp (describe below): ____ none needed

Do you feel the camper will require limitations or restrictions to activity while at camp? __ no __ yes
If you answered "Yes" to the question above, what do you recommend? (describe below-attach additional information if needed.)

I have discussed the camp program with the camper's parent/guardian . It is in my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

_____ _____ _____
Name of Licensed Provider (please print) **Signature** **Date**

_____ _____ _____ _____
Office Address **City** **State** **Zip Code**

_____ _____
Phone