

# SOPHIA FAHS

## Immunizations and Physical Exam Form

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Sophia Fahs Camp c/o Allyson Barish, 19A Lone Oak Drive, Centerport, NY 11721



CHILD'S NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

### IMMUNIZATION HISTORY

Provide the month and year for each immunization and have your healthcare provider review and sign below. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form

Which of the following has the camper had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test

Date of Last test: \_\_\_\_\_

Result:  Positive  Negative

Please give all dates of immunization for:

Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____
Tetanus/Diphtheria	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____
Tdap	_____	_____	_____	_____
Polio	_____	_____	_____	_____
MMR	_____	_____	_____	_____
or Measles	_____ or _____	_____	_____	_____
Mumps	_____ or _____	_____	_____	_____
Rubella	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____
Influenza	_____	_____	_____	_____

Meningococcal meningitis  Yes, Date received: \_\_\_\_\_

Immunizations:  No, I have chosen *not* to have my child vaccinated

If your camper has **NOT** been fully immunized, please attach the required legal documentation/support.

SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

### PHYSICAL EXAM

To be completed and signed by a licensed Health Care Professional. An official copy of child's last exam from July 1<sup>st</sup> of the last calendar year or more recent; please attach to this form.

I have examined the above applicant within the past year (circle one): YES | NO Date of Examination: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

In my opinion, the applicant (check one)  IS,  IS NOT able to participate in an active camp program.

Are there any medication to be administered at camp (circle one): NO | YES - please complete **MEDICATION RELEASE FORM**

Description of any limitation or restriction on camp activities: \_\_\_\_\_

Additional information for health care staff at the camp: \_\_\_\_\_



SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME OF LICENSED PROVIDER (PRINT): \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ DATE: \_\_\_\_\_