

# SUMMER CAMP HEALTH FORM

## Montgomery County Parks and Recreation

755 Roanoke Street, Suite 1E

Christiansburg, VA 24073

Phone: (540) 382-6975

Fax: (540) 382-4596

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

### TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

**Date of Exam** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_ May participate in all camp activities

\_\_\_\_\_ May participate except for: \_\_\_\_\_

Medical information pertinent to routine care and emergencies: \_\_\_\_\_

Is this individual taking prescription or over the counter medications(s)?  YES  NO

If yes, indicate the names of medication(s): \_\_\_\_\_

Does the individual have allergies?  YES  NO Explain: \_\_\_\_\_

Is the individual on a special diet?  YES  NO Explain: \_\_\_\_\_

Does the individual have special needs?  YES  NO Explain: \_\_\_\_\_

Is this camper up-to-date on all of the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices?:  YES  NO

**Continued on back**

Please give all dates of immunization for:

<b>Vaccine:</b>	<b>Dates:</b>	<b>M/Y</b>	<b>M/Y</b>	<b>M/Y</b>	<b>M/Y</b>	<b>M/Y</b>	<b>M/Y</b>
DTP							
TD (tetanus/diphtheria)							
Tetanus							
Polio							
MMR							
Or Measles							
Or Mumps							
Or Rubella							
Haemophilus influenza							
Hepatitis B							
Varicella (chicken pox)							

**Use this space to provide any additional information about the participant's health which the camp should be aware:** \_\_\_\_\_

\_\_\_\_\_

Name of physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Signature of Physician/Practitioner \_\_\_\_\_ Date \_\_\_\_\_