

2012 HEALTH HISTORY for LICENSED MEDICAL PERSONNEL

Name: _____
 Date of Birth: _____ Male Female
 Camp Name: Camp Bear Track Session: _____

Please have your child's primary healthcare provider complete this form. Once complete, scan and upload the document to your CampDoc.com account or return it to your camp.
 Keep the original copy for your own records

ACA accreditation standards require a physical exam within last 24 months
 Physical exam performed today? Yes No Date: _____
 If "No", date of last physical exam? _____

Height: _____
 Weight: _____
 Blood Pressure: _____

Immunization History Provide the month and year for each immunization Immunization records are attached

	Dose 1 <small>(Month/Year)</small>	Dose 2 <small>(Month/Year)</small>	Dose 3 <small>(Month/Year)</small>	Dose 4 <small>(Month/Year)</small>	Dose 5 <small>(Month/Year)</small>	
Diphtheria, tetanus, pertussis (DTaP or TdaP)	_____	_____	_____	_____	_____	TB Test Date: _____ <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Mumps, measles, rubella (MMR)	_____	_____	_____	_____	_____	
Polio (IPV)	_____	_____	_____	_____	_____	Tetanus Date: _____ (dT or TdaP)
Haemophilus influenzae type B (HIB)	_____	_____	_____	_____	_____	
Pneumococcal (PCV)	_____	_____	_____	_____	_____	Influenza Seasonal Date: _____ H1N1 Date: _____
Hepatitis B	_____	_____	_____	_____	_____	
Hepatitis A	_____	_____	_____	_____	_____	
Varicella (Chicken Pox)	_____	_____	_____	_____	_____	
Meningococcal meningitis (MCV4)	_____	_____	_____	_____	_____	<input type="checkbox"/> Had Chicken Pox? Date: _____

If patient is **NOT** fully immunized, please sign the following statement: I understand and accept the risks to the patient from **NOT** being fully immunized.

Printed Name _____ Relationship to Patient _____ Signature _____ Date _____

Restrictions List activity restrictions No restrictions

Past Medical / Surgical History

Diet / Nutrition List dietary restrictions Eats a regular diet

Allergies List all allergies and reactions No known allergies

Medications Include name, dose, frequency No medications

Physician Authorization:
 I have reviewed the patient health history form and have discussed the camp program with the patient's parents/guardians. It is my opinion that the patient is physically and emotionally fit to participate in an active camp program (except as noted above).

Address: _____ City: _____
 State: _____ Zip Code: _____ Phone: _____

Name of Licensed Provider _____ Signature _____ Date _____