



Please fill out all 3 pages of this form. Please print.

2010 ADULT CAMPER FORM

Last Name

First Name

Sex: _____

DOB: _____

Current Age: _____

Home Address

City / Town

State

Zip Code

Home Telephone

Telephone (Other)

Date of Last Physical Examination: _____ [physical examination must have been conducted during the preceding 24 months]

Please attach office copy of *Physical Examination* or *Physician note*

In case of Emergency contact:

Last Name

First Name

Home Address

City / Town

State

Zip Code

Home Telephone

Telephone (Other)



Health Care Provider Information:

Primary Care Physician Last Name

Primary Care Physician First Name

Primary Care Physician Phone Number

Primary Care Physician Address

Health Insurance Information/ Policy number:

**Certificate of Immunization
Required Immunizations – List month and year**

NOTE: You do not need to complete this page if you can submit a copy of your child’s immunization record. You can obtain a copy from your Pediatrician.

1. Measles, Mumps and Rubella (MMR) Vaccine: At least one dose of MMR vaccine(s) must be administered at or after 12 months of age or there must be proof of laboratory evidence of immunity. Attach list from physician that shows proof of immunization or fill in information below:

Date(s) of immunization: _____

2. Polio Vaccine: At least three doses of either trivalent oral polio vaccine (OPV) or enhanced potency inactivated polio vaccine (e-IPV) are required. If a mixed schedule of polio vaccine is given (IVP and OPV), a total of four doses is required.

Date(s) of immunization: _____

3. Diphtheria and Tetanus Toxoids and Pertussis Vaccine: At least four doses of DtaP/DTP/DT/Td are required. (The pertussis component is not given to anyone seven years of age or older). A booster dose of tetanus/diphtheria, adult type toxoid (Td) is required if more than ten years have elapsed since the last dose.

Date(s) of immunization: _____

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

Date(s) of immunization: _____

Exemptions from immunization:

Please submit a written statement explaining any religious objections to immunizations. Any immunization specified above in items 1 through 4 shall not be required if you submit a certification by a physician that he or she has examined you and that in the physician’s opinion your physical condition is such that your health would be endangered by such immunization.



SIGNIFICANT MEDICAL HISTORY – list dates (list past surgeries, and all medical conditions such as asthma, heart conditions etc.)

LIST ANY ALLERGIES, INCLUDING MEDICATION ALLERGIES: (be sure to list food allergies)

REQUIRED MEDICATIONS:

LIST HEALTH CONDITIONS OR IMPAIRMENTS WHICH MAY AFFECT YOUR PARTICIPATION IN SPORTS ACADEMY PROGRAM(S):

REMINDER: On the day of registration you may be asked to see the Camp Health Staff. The Health Staff will review your health forms and may perform a brief health screening. The health screening may include checking for head for lice, checking skin for rashes, and addressing any health concerns you may have. Please be sure to secure any medications you may need to take during your stay. The Health Staff is available to assist with medication administration as necessary.