MEDICAL EXAMINATION
(MUST BE COMPLETED & SIGNED BY A LICENSED PHYSICIAN)

Name _____

Home Phone (___) _____

Height _____ Weight _____

Special diet (Y) (N) _____
Allergies (Y) (N) _____
Chronic Illness / Condition (Y) (N) _____
Current Medications _____

Identify any known medical or emotional illness or disorder that would currently pose a risk to other children or which would currently affect the child's functional ability to participate safely _____

_____

Medical information pertinent to routine child care and emergencies: _____

_____

Is this child current, or in progress, with immunizations according to the schedule adopted by the Commissioner of Public Health? (Connecticut General Statute 19a-7f) (Y) (N)

IMMUNIZATION RECORD: (Month, Day, Year for each dose)

IMMUNIZATION	DATE					IMMUNIZATION	DATE
	1ST DOSE	2ND DOSE	3RD DOSE	4TH DOSE	5TH DOSE		
DTP / DTaP / DT						MMR (1st Dose)	
OPV / IPV						MEASLES (2nd Dose)	
Hib (HAEMOPHILUS INFLUENZA TYPE B)						VARICELLA (Chicken Pox) (Recommended)	
HEPATITIS B						OTHER (Specify)	

The above person is in satisfactory condition and may engage in all camp activities except as noted.

Signature of MD, APRN, or PA _____

Name (Please Print) _____

Address _____

Date form signed _____ Telephone _____

State License in _____ License # _____

Date of Examination _____