SPRINGFIELD COLLEGE / Office of Conferences and Special Events

HEALTH RECORD

INSTRUCTIONS: THIS FORM MUST BE SIGNED AND DATED BY A PHYSICIAN

Camp: _____

Camper Name: _____
Last First M.I.

DOB: _____/_____/_____ Gender_____ Age while in camp: _____

Parent/Guardian:

Name_____ Relation to Child: _____
Last First

Address: _____
Street Town/City State Zip

Phone (Day): (_____) _____-_____ Phone (Evening): (____) _____-_____

Health History: Provide dates and other information requested or indicate N/A.

Ear Infections	_____	Chicken Pox	_____	Measles	_____
Convulsions	_____	German Measles	_____	Diabetes	_____
Mumps	_____	Bleeding Disorder	_____	Tuberculosis	_____

Operations/serious injuries: _____

_____

Disability or chronic or recurring illness: _____

_____

IMMUNIZATIONS: THIS SECTION MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER OR ATTACH A COPY OF IMMUNIZATION DOCUMENTATION OR ALTERNATIVE PROOF OF IMMUNITY.

REQUIRED IMMUNIZATIONS (Campers under 18)	DATE (Month/Day/Year)
MMR (1st dose age 12 months or older)	
Measles #2 or MMR #2 (Given at age 4-6)	
Polio (3 doses of OPV or IPV or 4 doses of mix IPV or OPV)	#1 #2 #3 #4
Diphtheria and Tetanus Toxoids and Pertussis	#1 #2 #3 #4 Booster (if applicable)
Hepatitis B (3 doses if born on or after January 1, 1982)	#1 #2 #3

LEAD SCREENING: _____

Effective 3/01/90 Massachusetts State Law requires all children, regardless of risk, to be screened at least once between ages of 9-12 months and annually until the age of 48 months. Children under 3 years who are determined to be at high risk for lead exposure must be screened every 6 months, and yearly from 3 years to 6 years. Children must present evidence of having been previously screened as a condition for entry to kindergarten.

Physical examination by a physician: This section must be completed by a physician or attach a copy of a physical examination conducted by a medical provider during the preceding 24 months.

Height:	Eyes:	Abdomen:
Weight:	Vision:	Genitalia, Hernia:
BP:	Ears, Nose, Throat:	Musculoskeletal:
HCT or Hgb:	Heart:	Neurological Exam:
Urinalysis:	Lungs:	Skin:

DATE OF LAST PHYSICAL EXAM: _____

Recommendation for camp participation:

- Is person capable of participating in active camp programs? ☐ **YES** ☐ **NO**
- Please explain any restrictions_____
- Is person currently taking medications? _____
  _____
  _____
- List any medications to be administered by Camp Health Supervisor:
  _____
  _____
  _____

Signature of Health Care Provider: _____ **Date**: _____

Printed Name of Health Care Provider: _____

Office Address: _____ **Phone**: _____

PLEASE UPLOAD THIS FORM ALONG WITH:

- COPY OF THE PARTICIPANTS MOST RECENT PHYCICAL EXAM SIGNED BY A PHURICIAN OR MEDICAL PROVIDER
- COPY OF IMMUNIZATION RECORDS
- COPY OF HEATH INSURANCE CARD (FRONT & BACK)