Springfield College Camp Massasoit 263 Alden Street Springfield, MA 01109-3797

2021 Emergency Contact and Health Record

	Child's Name:						ender:	
Parents/Guardian: Address:			Last		First	M.I.		
Last First Street Town/City State Zip Code Phone (Home): () Phone (Work): () Phone (Cell): ()	OOB:	_/		Age in cam	o:			
Last First Street Town/City State Zip Code	Parents/Guard	lian:						
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Phone (Home): ()	Address:							
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Name of Family Physician: Phone #	Name of Family	y Physi	cian:			Phone #		
	Signature of P	arent/0	Guardian:			Date	e:	

IMPORTANT: Camp Massasoit must be notified immediately if a camper has been exposed to a communicable disease during or within three weeks prior to attendance.

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 years of age)	DATE (Month/Day/Year)	
MMR (1st dose age 12 months or older)		
Measles #2 or MMR #2 (Given at age 4 – 6 years and at least 1 month after 1 st dose)		
	#1	
Polic (2 deeps of OD) / or ID) / or 4 deeps of rain ID) / and OD) ()	#2	
Polio (3 doses of OPV or IPV or 4 doses of mix IPV and OPV)	#3	
	#4	
	#1	
Dintheric and Tetanua Toyoida and Portugaia (4 deeps of DToD/DTD/DT/Td	#2	
Diptheria and Tetanus Toxoids and Pertussis (4 doses of DTaP/DTP/DT/Td.	#3	
Booster dose of Td required if more than 10 years since last dose)	#4	
	Booster (if applicable)	
	#1	
Hepatitis B (3 doses if born on or after January 1, 1992)	#2	
	#3	

LEAD SCREENING:

Effective 3/01/90 Massachusetts State Law requires all children, regardless of risk, shall be screened at least once between the ages of 9-12 months and annually until the age of 48 months. Children who are determined to be at high risk for lead exposure must be screened every 6 months and 3 years 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 physician during the preceding 24 months.

DATE OF MOST RECENT PHYSICAL EXAM:

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

Recor	mmendation for Camp Participation:			
ls	person capable of participating in active camp program(s)?	Yes	No	
PI	ease explain any restriction(s)			
ls	person currently taking medication(s)?			
Lis	st any medications to be administered by Camp Health Supervisor	r		
Signat	ture of Health Care Provider:		Date:	
	d Name of Health Care Provider:	Phone:		
Office	Address:			