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

2022 Emergency Contact and Health Record

Child's Name:					Ge	ender:
		Last		First	M.I.	
DOB:	_/	/	Age in camp	:		
Parents/Guard	lian:					
Name:					Relation to Child:	
	Last		First			
Address:						
	#	Street	Towi	n/City	State	Zip Code
Phone (Home):	: ()	Phone (Work): ()	Phone (Cell): ()	-
Name:					Relation to Child:	
	Last		First			
Address (if diffe	erent fro	om above):				
	#	Street	Towi	n/City	State	Zip Code
Phone (Home)	: ()	Phone (Work): ()	Phone (Cell): ()	-
O A			-4.			
One Additiona					Polation to Child:	
iname			Firet		Relation to Child:	
A ddraga.	Last		First			
Address	#	Street	Томи	n/City	State	Zin Codo
Phone (Home)				•	Phone (Cell): ()	•
PLEASE COM			i none (work). (/		 -
			ormission for my child to	a usa hand	sanitizer, that has at least 60	0% alcohol pro
					ate handwashing facility.	
vided by Carri	p iviass	ason in the e	event my child is not nea	ı alı au c qu	ate nandwashing facility.	TES NO
Health History	ː Provi	ide dates and	l other information reque	ested or inc	dicate N/A (not applicable) if	appropriate.
Ear Infections			Chicken Pox		Measles	
Convulsions			German measles		Diabetes	
Mumps			Bleeding disorder		Tuberculosis	
Allergies:						
Operations/Ser	ious Inj	juries:				
Disability or ch	ronic or	recurring illne	ess:			
Family Medical Insurance Carrier:						
Name of Dentist/Orthodontist:						
Name of Family Physician:						
Signature of P	Parent/0	Guardian:			Date:	

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.

<u>Immunizations</u>: 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 does of OD) (or ID) or 4 does of mir ID) (ord OD))	#2
Polio (3 doses of OPV or IPV or 4 doses of mix IPV and OPV)	#3
	#4
	#1
Dinthorio and Tatonus Tavaida and Partugais // dassa of DT-D/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
	#1
COVID- 19	#2
	Booster (if applicable)

ı	FΔ	ΔD	SC	RF	FΝ	ING:	
ᆫ	-	\mathbf{v}	\sim	╵┖	டா	II VO.	

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.

<u>Physical Examination By a Physician</u>: 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:	

Urinalysis:	Lungs:	Skin:		
Recommendation for Ca	mp Participation:			
• Is person capable of p	participating in active camp program(s)?	Yes	No	
• Please explain any re-	striction(s)			
 Is person currently taken 	king medication(s)?			
 List any medications t 	o be administered by Camp Health Superviso	r		
Signature of Health Care I	Provider:		Date:	
Printed Name of Health C			Phone:	

Office Address: