

Return form to program:

Participant Name: (print) _____
(Last) (First) (MI)

**MEDICAL AND IMMUNIZATION HISTORY
PROGRAMS AND CAMPS**

Section I: (To be completed by Parent or Guardian)

Name: _____ Sex: M F Birth date: _____
Month/Day/Year

Address: _____ City: _____ State: _____ Zip: _____

Program Name: _____ Program Dates: _____ to _____ Soc. Sec: _____ - _____ - _____

Father: _____ Telephone: _____ Telephone: _____
(Day time) (Evening)

Mother: _____ Telephone: _____ Telephone: _____
(Day time) (Evening)

Guardian is: Father: _____ Mother: _____ Other (Name & Address): _____
Telephone Number: _____

In case of illness or emergency the name and telephone number of a person to contact: (Relation to participant)

Family Physician or HMO (Name & Address): _____

Family Physician or HMO Telephone Number: _____

Family Dentist (Name & Address): _____

Family Dentist Telephone Number: _____

Medical Insurance Company Name: _____ Policy Number: _____

In case of medical emergency, I hereby give permission to the University Health Service staff to hospitalize, to secure proper treatment for, and to order injection or minor surgery for my child, as named above.

Date: _____ Parent/Guardian Signature: _____

Section II:

Physical Examination: (Must be in the preceding 12 months and done by a Medical Provider)

Medical History: (Please note significant disorders)

Allergies _____	Heart _____	Tuberculosis _____
Allergies _____	Kidney _____	Whooping Cough _____
Diabetes _____	Lung _____	Varicella _____
Disabilities _____	Neurological _____	Other _____

Pertinent Medical History:

Child Name: _____ Sex: M F Birth date: _____

Section III:

Summary of Significant Treatment Program Including Names/Doses of Medications to be used while at program:
(Medications **MUST** be in a container with the original label)

Section IV: Immunizations

Immunization	Dates	Immunizations	Dates
Has completed primary series of tetanus/diphtheria? (Four doses) Yes _____ No _____.			
Completed primary series of polio immunizations? Yes _____ No _____. Primary Series -- Type of vaccine: OPV IPV E - IPV ____/____/____. Last Booster -- Type of vaccine: OPV IPV E - IPV ____/____/____.			
Diphtheria/Tetanus (Td) Must be within last ten years (Complete only if primary series was more than ten years ago.	Month/ Day/ Year ____/____/____.	Mumps or MMR # 1 Must be AFTER age 12 Months OR Positive Mumps Titer (blood test)	Month/ Day/ Year ____/____/____. Month/ Day/ Year ____/____/____.
Measles # 1 (Rubeola, Red Measles) – Must be AFTER age 12 Months Or MMR # 1 Or Positive Measles Titer (blood test)	Month/ Day/ Year ____/____/____. Month/ Day / Year ____/____/____. Month/ Day / Year ____/____/____.	Rubella or MMR # 1 (German Measles) – Must be AFTER age 12 Months OR Positive Rubella Titer (blood test)	Month/ Day/ Year ____/____/____. Month/Day/ Year ____/____/____.
Measles # 2 (Rubeola, Red Measles) – Must Be at least 30 days AFTER first dose Or MMR # 2	Month/ Day/ Year ____/____/____. Month/ Day /Year ____/____/____.	Hepatitis B Those born AFTER 1-1-92 Dose # 1 Dose # 2 Dose #3	Month/ Day/ Year ____/____/____. ____/____/____. ____/____/____.
Medical exemption: The above named person does not have one or more of the required immunizations because he/she has A medical problem that precludes the _____ vaccine(s).			

Health Care Provider Signature and/or stamp: _____ Date: _____
Printed Names: _____
Address: _____ Telephone #: _____