SOPHIA FAHS
Immunizations and Physical Exam Form

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CHILD's NAME:______________________________ **D.O.B.:** ____________

IMMUNIZATION HISTORY

Provide the month and year for each immunization and have your healthcare provider review and sign below. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form

Which of the following has the camper had?

- ❑ Measles
- ❑ Chicken Pox
- ❑ German Measles
- ❑ Mumps
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C

TB Mantoux Test

Date of Last test:__________

Result: ❑ Positive ❑ Negative

Please give all dates of immunization for:

Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	______	______	______	______
Tetanus/Diptheria	______	______	______	______
Tetanus	______	______	______	______
Tdap	______	______	______	______
Polio	______	______	______	______
MMR	______	______	______	______
or	Measles	______	______	______
or	Mumps	______	______	______
or Rubella	______	______	______	______
Hepatitis B	______	______	______	______
Varicella (chicken pox)	______	______	______	______
Influenza	______	______	______	______

Meningosoccal meningitis immunizations: ❑ Yes, Date received:_______
❑ No, I have chosen *not* to have my child vaccinated

If your camper has **NOT** been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized

SIGNATURE OF PARENT/GUARDIAN:______________________________DATE:__________

PHYSICAL EXAM

To be completed and signed by a licensed Health Care Professional. An official copy of child's last exam from within the 12 months is acceptable; please attach to this form.

- I have examined the above applicant within the past year (circle one): YES | NO Date of Examination:______________

  Height: ______________Weight: ______________Blood Pressure: ______________

- In my opinion, the applicant (check one) ❑ IS, ❑ IS NOT able to participate in an active camp program.
- Are there any medication to be administered at camp (circle one): NO | YES - please complete **MEDICATION RELEASE FORM**
- Description of any limitation or restriction on camp activities: ______________________________
- Additional information for health care staff at the camp:______________________________

SIGNATURE OF **PARENT/GUARDIAN**:______________________________DATE:______________

NAME OF **LICENSED PROVIDER** (PRINT):______________________________SIGNATURE:______________

OFFICE ADDRESS:____

TELEPHONE:______________________________DATE:______________