

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	Date	Immunizations	Dates
Has completed primary series of tetanus/diphtheria? (Four Does) 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 ___/___/___.			
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 Positvie 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 Postive 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 Postive Mumps Titer (blood test):	Month/ Day/ Year ___/___/___ Month/ Day/ Year ___/___/___
Measles #2 (Rubeola, Red Measles)- Most 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 stamps: _____ Date: _____

Printed Names: _____

Address: _____ Telephone #: _____

Return form to Program

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

**MEDICAL AND IMMUNIZATION HISTORY
PROGRAM AND CAMPS**

Section I: (To be completed by Parent or Gaurdian) _____

Name: _____ Sex: M F Birthdate (Month/Date/Year): _____

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

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

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

Mother: _____ Telephone (Day): _____ Telephone (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 sugery for my child, as named above.

Date: _____ Parent/ Guardian Signature: _____

Section II:

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

Medical History: (Please note significant disorders)

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

Medical History: _____