

- If you are 18 or older you may sign this form yourself.
- If you are under 18, a parent or guardian must sign.

Mohawk Day Camp

COUNSELOR MEDICAL FORM 2008

NAME: _____ DOB: _____ AGE: _____
(Please print)

DATES OF IMMUNIZATIONS:

- *If born before 1/1/57 documentation is not required.*

Diphtheria 3 or more doses of diphtheria toxoid _____

Polio 3 or more doses trivalent oral poliovirus vaccine (TOPV) _____

Measles 1 dose of live measles vaccine administered after the age of 12 months _____
2nd dose administered at least 3 month after the first _____

Mumps 1 dose of live mumps vaccine administered after the age of 12 months _____

German measles (Rubella) 1 dose of live rubella virus vaccine administered after the age of 12 months of serological evidence (blood test) of rubella antibodies _____

Tetanus _____

Are you currently on any medication? Yes No

If yes, please list: _____

Do you require use of an epi-pen? Yes No

HISTORY:

Allergies _____ Medications _____

Illnesses _____ Operations _____

Injuries _____ Other _____

~ Turn Over ~

PHYSICAL EXAM: *Leave blank if normal.*

Date of last Exam _____

Height _____	Weight _____	Blood Pressure _____
Eyes _____	Ears _____	Nose _____
Throat _____	Teeth _____	Heart _____
Lungs _____	Abdomen _____	Genitourinary _____
Skin _____	Orthopedic _____	Lymph nodes _____
Speech _____	Nutrition _____	Nervous system _____

Other _____

Limitation of activities _____

Behavior or emotional problems _____

Diagnosis or explanation of above _____

Other _____

EMERGENCY CONTACTS (please list two)

Name & Relationship	Phone Number
1. _____ _____	Home: _____ Cell: _____
Relationship	
2. _____ _____	Home: _____ Cell: _____
Relationship	

PARENT / STAFF MEMBER SIGNATURE: _____

PRINT NAME: _____

DATE: _____

EMERGENCY MEDICAL TESTING AND TREATMENT AUTHORIZATION

I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests, and treatment for me or my child. If I cannot be reached in an emergency concerning my child, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment and to order injections and/or anesthesia and/or surgery for me or my child as named below. This form may be photocopied for use out of camp.

Name of Camp staff member: _____ Date: _____

Signature of Staff Member or parent, if a minor: _____