



# Camp Hawkeye

## CAMP HEALTH MEMORANDUM

*(This page must be completed and signed by a qualified health professional.)*

New Hampshire State Law requires that any individual attending or working at Camp must have had a physical examination in the previous two years and that all required immunizations be up to date before the beginning of their period of attendance. (A copy of the current school physical form may be used for this section.)

Physical (Name) \_\_\_\_\_ has been examined on (date) \_\_\_\_\_.

DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ HR: \_\_\_\_\_

Existing medical conditions? Yes  No  Please explain: \_\_\_\_\_

Allergies: Yes  No  Please specify: \_\_\_\_\_

Is there any factor precluding the individual from participating fully, in the Camp program? Yes  No   
Please specify any limitations: \_\_\_\_\_

Immunizations Are immunizations up to date? (Please check appropriate box **and** add date)

Tetanus/Diphtheria/Pertussis Booster (Tetanus Booster within the last five years)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Measles, Mumps, and Rubella	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Hepatitis B (At least initial immunization for children born after January 1, 1993)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Polio	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____

**\*\*Please complete this section or attach a copy of the Immunization Record to this form\*\***

Medications **\*\*\*EACH MEDICATION MUST BE IN ITS ORIGINAL CONTAINER\*\*\***

**Prescription medication directions and authorization: (Must be completed and signed by physician)**

Is the individual on any prescription medications? Yes  No

Medication and dosage \_\_\_\_\_ Reason for giving \_\_\_\_\_  
Directions for administration (routine or PRN) \_\_\_\_\_

Medication and dosage \_\_\_\_\_ Reason for giving \_\_\_\_\_  
Directions for administration (routine or PRN) \_\_\_\_\_

Medication and dosage \_\_\_\_\_ Reason for giving \_\_\_\_\_  
Directions for administration (routine or PRN) \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Telephone: \_\_\_\_\_

Print/Stamp

MD

www.camphawkeye.com