



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