CAMP BURGESS & HAYWARD HEALTH FORM

A PHYSICAL EXAMINATION BY A LICENSED HEALTHCARE PROVIDER MUST BE DOCUMENTED ON THIS FORM. THE EXAMINATION MUST TAKE PLACE NO MORE THAN 12 MONTHS PRIOR TO ATTENDANCE.
AN OFFICIAL PRINTED REPORT OF THE EXAMINATION CAN BE SUBSITUTED, BUT MUST GIVE ALL THE INFORMATION THIS FORM ASKS FOR. ALL INFORMATION ASKED FOR ON THIS FORM IS *REQUIRED BY LAW*.

IMMUNIZATION VERIFICATION — REQUIRED BY MASSACHUSETTS LAW

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month / Year
Diptheria, Tetanus, Pertussis (DTaP) or (TdaP)						
Mumps, Measles, Rubella (MMR)						
Polio						
Hepatitis B						

I have examined the person named below:

Camper/Staff Name: _____ **Examination Date:** _____
mm dd yyyy

_____ physician's initials — **In my opinion the person named on this form IS healthy enough to participate fully in an active camp program.**

_____ physician's initials — **In my opinion the person named on this form IS NOT healthy enough to participate fully in an active camp program.**

The camper/staff named above is under a physician's care for the following condition(s):

Current treatment – include current medication(s):

Does this camper /staff have tuberculosis in a communicable form or symptoms thereof? ☐ Yes ☐ No

Does the camper /staff have epilepsy? ☐ Yes ☐ No

Does the camper /staff have diabetes? ☐ Yes ☐ No

If female, is her menstrual history normal? ☐ Yes ☐ No

Recommendations and/or restrictions for this individual while at Camp
(any treatment to be continued; any medication to be administered; any dietary restrictions; any allergies to foods, drugs, plants, insects, etc.):

Additional information:

Physician's Signature: _____ **Printed Name:** _____

Address: _____ **Phone:** _____ **Date:** _____
mm dd yyyy