

NAME _____ WARD _____ STAKE _____

Please note that your information will be kept in confidence. Only the nurse & camp director will see this form.
EXAM MUST BE WITHIN THE PAST TWO YEARS AND MUST BE SIGNED BY YOUR PRIMARY CARE PROVIDER .
PLEASE KEEP A COPY OF THIS FORM FOR YOUR PERSONAL RECORDS

LICENSED PHYSICIAN'S HEALTH EXAMINATION (Exam must be within last 24 months.)

Date of Examination _____ Physician's name (print please) _____

Height _____ Weight _____ B/P _____ Pulse _____ Glasses or Contacts (Y/N) _____

Eyes _____ Ears _____ Nose _____ Throat _____ Teeth _____
 Heart _____ Lungs _____ Respiratory _____ Abdomen _____
 GU _____ GI _____ Neuro _____ Musculoskeletal _____ Other _____

EMERGENCY MEDICAL INFORMATION

Has or is subject to (check and give details):

- ___ Allergies to a medicine, food, plant, animal, or insect toxin.
- ___ Any condition that may require special care, medication, or diet.
- ___ Asthma ___ Seizures ___ Heart Trouble ___ Fainting Spell ___ ADD/ADHD
- ___ Cancer ___ Bipolar Disorder ___ Bleeding Disorder ___ Anxiety Disorder
- ___ Diabetes ___ Congenital Disorder ___ Other _____

EXPLAIN _____

IMMUNIZATION DATES (May also attach copy of completed immunization from physician's office **)**
In accordance with NH Camp regulation: RSA 141-C:20-c the following immunizations are required:

Adult		Youth			
Immunization	Date	Immunization	Date		
Measles (for those born on or after 1-1-1957; two total[may have had first as a youth] or titer)		MMR (two total)			
Mumps (either one dose [may have had as a youth], history of disease, or titer)		Polio (3 doses; 4 doses if 3rd dose given before age 4)			
Rubella (either one dose [may have had as a youth], or titer)		DPT (at least three doses; Td or Tdap booster within last ten years)			
Tetanus/Diphtheria (Td or Tdap booster within last ten years)		Hepatitis B (for those born on or after 1-1-1993; at least the first out of three in series)			
		Varicella ("Chicken Pox", vaccine or history of disease)			

Licensed physician's comments and recommendations: Give details or indicate management of significant illness.

This person is in satisfactory condition and may engage in all usual activities except as noted above.

Licensed Physician's Signature _____ Date _____