



MEDICAL FORM

According to Massachusetts General Law 105CMR 430.00 ALL CAMPERS MUST SUBMIT, IN COMPLETION, THE HEALTH FORM BELOW

Participant Name (print) _____

Section I: (to be completed by parent/guardian)

Name: _____

Birthdate: _____

Address: _____

City: _____ State _____ Zip _____

Program Name: _____

Program Dates: _____ to _____

Father: _____ Mother: _____

Day Phone: _____ Day Phone: _____

Evening Phone: _____ Evening Phone: _____

Guardian is: Father _____ Mother _____ Other _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Day Phone: _____ Evening Phone: _____

In case of illness or emergency the name and telephone number of a person to contact (relation to participant) _____

Family Physician or HMO:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Family Dentist:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Medical Insurance Company: _____

Policy Number: _____

In case of medical emergency, I hereby give permission to the certified WMHS Athletic Training staff member to hospitalize, to secure proper treatment for, and to order minor injection or minor surgery for my child, as named above.

Signature of parent: _____



Section II: Physical Examination (Must be in the preceding 24 months by a Medical Provider)

Child Name: _____

Birthdate: _____

Summary of significant treatment program including name/dose of medications to be used while at program (medication must be in a container with the original label)

Medical History (check significant disorders)

Allergies: _____ Heart: _____ TB: _____

Kidney: _____ Lung: _____ Diabetes: _____

Varicella: _____ Disabilities: _____ Neurological: _____

Whooping Cough: _____ Other: _____

Pertinent Medical History:

Section III: Immunizations

Completed primary series of tetanus/diphtheria? (four doses)

Yes: _____ No: _____

Completed primary series of polio immunizations?

Yes: _____ No: _____

Primary series-Type of Vaccine OPV IPV E-IPV _____/_____/_____

Laser Booster-Type of Vaccine OPV IPV E-IPV _____/_____/_____

IMMUNIZATIONS

DATES

Diphtheria/Tetanus (must be within last 10 years) _____/_____/_____

Measles #1 (must be after age 12 months) _____/_____/_____

(rubeola, red measles)

MMR#1 _____/_____/_____

Or Positive Measles Titer (Blood test) _____/_____/_____

Measles #2 (must be at least 30 days after first dose) _____/_____/_____

(rubeola, red measles)

Or MMR#2 _____/_____/_____

Mumps or MM#1 (must be after age 12 months) _____/_____/_____

Or Positive Mumps Titer (blood test) _____/_____/_____

Rubella (German measles) or MMR#1 (after age 12 mos) _____/_____/_____

Or Positive Rubella Titer (blood test) _____/_____/_____

Hepatitis-B (those born after 1-1-92)

Dose 1: _____/_____/_____ Dose 2: _____/_____/_____ Dose 3: _____/_____/_____

Medical exemption: The above named person does not have one or more of the required immunizations because of a medical problem(s) that precludes the _____ vaccine(s).

Health care provider/physician:

Signature/stamp and date: _____

Printed name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____