



# HEALTH RELEASE FORM

This form **MUST** be completed by a licensed physician and returned with the registration form.

CHILD'S NAME \_\_\_\_\_ GRADE IN SEPT. 2018 \_\_\_\_\_

## Immunization History

<i>Vaccines</i>	<i>DATES</i>					
DTP						
Haemophilus Influenza b (HIB)						
Polio						
Measles/Mumps/Rubella (MMR)						
Hepatitis B						
Tuberculin Test Given						
Pneumococcal Conjugate (PCV)						
Varicella						
Other: _____						

## Physician's Health Care Recommendations

The last date I examined the above applicant was _____ (Date Examined)		
The above's condition <input type="checkbox"/> DOES <input type="checkbox"/> DOES NOT preclude his/her participation in a summer camp/after school care program.		
Height	Weight	Blood Pressure
The applicant is under the care of a physician for the following condition(s):		
Current treatment (include current medications):		
Explanation of any reported loss of consciousness, convulsion, or concussion:		
Does Applicant have epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does Applicant have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No

## Recommendations & Restrictions While at Summer Camp

Any treatment to be continued at site?
Any allergies (food, drugs, plants, insects, etc.)?
Any medication to be administered at site (specific dosages)?
Additional health information

## PHYSICIAN'S SIGNATURE

Licensed Physician's Signature	
Address:	Phone #
Date Form is Completed:	If Form Completed by Nurse, please initial: