PARTICIPANT MEDICAL INFORMATION

Please attach a copy of the camper's Immunization records (preferred) or complete dates of the following immunizations (required by the NY State Department of Health).

Vaccination 1st Date 2nd Date 3rd Date 4th Date 5th Date

DPT____
DT/TD____
Tdap____
POLIO____
HIB____
MMR____
HEP-B____
VARICELLA____
H1N1 (not a requirement) ____

Medical Information:
Date of last physical exam ____________________(must have been within the last year)
Name of Physician____________________ Telephone Number (____)____________
Family History: (list all familial diseases, such as Diabetes, Tuberculosis, Epilepsy, etc.)
____
____

Personal History: (Check those of the following diseases or conditions that the camper has had)

___allergy injections
___chicken pox
___congenital or heart prob.
___emotional disorder
___infectious jaundice
___measles
___mononucleosis
___hearing impairment
___psychiatric disease
___rheumatoid arthritis
___tuberculosis
___anemia
___chronic intestinal prob.
___diphtheria
___frequent colds
___kidney disease
___Rubeola(English/Red)
___orthapedic problems
___poliomyelitis
___rheumatic fever
___seizure disorder
___whooping cough
___bronchitis
___diabetes
___eczema
___sore throats
___malaria
___Rubella(German)
___otitis media
___pneumonia
___scarlet fever
___speech defect
___NONE OF THE ABOVE
___epilepsy
___hives
___hepatitis
___hay fever
___malignancy
___mumps
___tonsillitus
___sinusitis
___TB contact

Severe injuries/operations (with dates)______________________________________
Any known allergies____
Medical Problems____

Physician Recommendations/Restrictions (To Be Completed By Physician)
Diet:____
Medications:____
Physical Activity:____

Physician Signature:______________________________ Date________________________

Please return all medical forms to:
Beth Costello (Hoop Mountain Health Director)
137 Davis St.
Painted Post, NY 14870

For questions concerning medical forms please e-mail
Beth Costello at:
erc0426@yahoo.com