REDWOOD ADVENTURE CAMP
IMMUNIZATION RECORD & DOCTOR'S FORM

Information on this form is not part of the camper acceptance process but is gathered to assist us in identifying appropriate care. Parents, please fill out the top portion of this form and have your child's physician fill out the bottom portion and mail *at least* ***THREE WEEKS BEFORE CAMP SESSION*** to:
Redwood Adventure Camp, PO Box 9447, Santa Rosa, CA 95405-1447

Name_____ **Age** _____ **Sex** _____ **Birthday** _____
(Last) (First)

Home Address _____ **Phone**_____
Street & Number City State Zip

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

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)						
Tetanus booster★ (dT) or (TdaP)						
Mumps, measles, rubella★ (MMR)						
Polio★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative	☐ Positive

If your camper has not been fully immunized, please sign the following statement: **I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

Health Care Recommendations by Licensed Physician

Physical exam done today: ☐ Yes ☐ No (**If "No", date of last physical**: _____ Month/Day/Year)

In my opinion, the applicant's condition ☐ **does** ☐ **does not** preclude his/her participation in an active camp program.

Blood Pressure _____ Height _____ Weight _____

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? ☐ Yes ☐ No Does applicant have diabetes? ☐ Yes ☐ No

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp _____

Any medication to be administered at camp (specific dosages) _____

Any medically prescribed meal plan or dietary restrictions _____

Any allergies (food, drugs, plants, insects, etc.) _____

Activities to be encouraged or limited _____

Additional Health Information _____

Licensed Physician's Signature _____

Address_____ Phone _____

Date of Form Completion _____ *By _____
*Initial if completed by nurse or physician's assistant