WINSTON DAY CAMP STAFF MEDICAL FORM

NAME:____
FIRST LAST MIDDLE

HOME ADDRESS______________________________________

PHONE NUMBER____________________ **AGE**________

DATE OF BIRTH____________**HEIGHT**_________ **WEIGHT**_____

IMMUNIZATION RECORD: Please list all dates required

(A) **MENINGOCOCCAL MENINGITIS** ____________________________
(B) 3 doses of **DIPHTHERIA TOXOID**____________________________
(C) 3 doses of **ORAL POLIO VACCINE**__________________________
(D)1 dose of **LIVE MUMPS VACCINE**____________________________
(E) 1 dose of **LIVE MEASLES VACCINE**__________________________
(F) 1 dose of **LIVE RUBELLA VACCINE**__________________________
(G) **LAST TETANUS BOOSTER** _________________________________
(H) **VARICELLA (Chicken Pox)** ________________________________
(I) **HAEMOPHILUS INFLUENZA TYPE B** ___________________________
(J) **HEPATITIS B** ____

____

Do you have any allergies: __________________(Please note)__________

Are you allergic to any medication____________________

If so, indicate alternative medication used____________________________

Will you be bringing any medication up to camp? Yes_____ NO_____

If so, name of medication_________________ Treatment for_______________

Dosage_____________ When given:___________ How often___________

....

Please note any **Physical Restrictions** _________________________________

Please note any **Dietary Restrictions**___________________________________

Date of Camp Physical Examination_________ **Physician's Name**________________

Address________________________________ Telephone:_________________

Staffer is physically able to enter into all camp activities.

Physician's Signature________________________ Date:____________

(Please turn over)

PERSON TO NOTIFY IN CASE OF A MEDICAL PROBLEM:

Name:___________________________ **Relationship**________________

Address:____

____

Phone Number:___________________________________

....

Signature of Staff Member:_______________________________

Date:_________________________