Camp Strong4Life
Camper Immunization Form

Please provide the month and year for each immunization. Starred (*) immunizations must be current. **Copies of immunization forms from healthcare providers or state or local government (Form 3231) are preferred; please attach to this form.**

CAMPER NAME: _____ **DOB:** ___/___/___

PARENT/GUARDIAN NAME: _____

Immunization	Dose 1 (mm/yy)	Dose 2 (mm/yy)	Dose 3 (mm/yy)	Dose 4 (mm/yy)	Dose 5 (mm/yy)	Most Recent Dose (mm/yy)
Diphtheria, tetanus, pertussis* (DTaP or Tdap)						
Tetanus booster (Td or Tdap)						
Mumps, measles, rubella (MMR)*						
Haemophilus influenzae type b (Hib)						
Polio (IPV)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella* (Chicken Pox) or **History of Disease:** Y/N **Date:**						
Meningococcal meningitis (MCV4)						
Influenza						

COVID-19

To ensure the safety of all campers, volunteers and staff, the COVID-19 vaccine is **required** to attend camp. Please complete the information below and attach your COVID-19 vaccine card to keep on file.

Vaccine	Manufacturer	Dose 1 (mm/yy)	Dose 2 (mm/yy)	Booster (mm/yy) *if applicable*
COVID-19				

I verify that all of the dates above are correct.

Signature of Custodial Parent/Guardian: _____ Date: _____

Relationship to Camper: _____

Please email or fax a copy of the Immunization Form and Medical Form to Camp Strong4Life.

Email: CampStrong4Life@choa.org **Fax:** 404-785-3241

Camper Medical Form

This form is to be completed by a licensed physician. Examination required within 12 months of camp.

Patient Information					
Name:			DOB:	Gender:	Age:
Physician:		Phone:		Date of Last Exam:	
Medical Information					
Height:		Weight:		B/P:	
Explain below using code: (S) Satisfactory or (NS) Not Satisfactory				Extremities: ❍S ❍NS	
Throat: ❍S ❍NS	Nose: ❍S ❍NS	Heart: ❍S ❍NS	Skin: ❍S ❍NS	Lungs: ❍S ❍NS	Eyes: ❍S ❍NS
Ears: ❍S ❍NS	Abnormal Findings:				
Daily medications to be continued at camp? ❍Y ❍N	If yes, please describe the dose and frequency:				
Is the applicant under the care of a physician for any conditions? ❍Y ❍N					
Do you feel that the camper will require limitations or restrictions to activity while at camp? ❍Y ❍N					
Other treatments/therapies to be continued at camp? ❍Y ❍N					
If yes, please explain:					
Patient History					
Heart Defect/Disease ❍Y ❍N		ADD/ADHD ❍Y ❍N		Tuberculosis ❍Y ❍N	
Recent Hospitalization ❍Y ❍N		Head Lice (Recent) ❍Y ❍N		Chicken Pox ❍Y ❍N	
Asthma ❍Y ❍N		Diabetes ❍Y ❍N		Seizures ❍Y ❍N	
For each "yes," please explain and list reactions:				Other Diseases/Conditions ❍Y ❍N	
Patient Allergies					
Hay Fever ❍Y ❍N	Oak/Ivy Poisoning ❍Y ❍N	Bee Stings ❍Y ❍N	Seasonal ❍Y ❍N	Foods ❍Y ❍N	Medications ❍Y ❍N
Any medically prescribed meal plan or dietary restrictions?			For each "yes," please explain and list reactions:		
Non-Prescription Medications: *I **DO NOT** authorize the following medications (or generic equivalent) to be administered as needed*					
❍ Tylenol	❍ Chloraseptic	❍ Sucrets	❍ Cough drops	❍ Pepto-Bismol	❍ Benadryl
❍ Cough syrup	❍ Sudafed PE	❍ Sudafed	❍ Lice shampoo	❍ Calamine	❍ Scabies cream
❍ Aloe	❍ Guaifenesin	❍ Hydrocortisone 1% cream		❍ Ibuprofen	❍ Ex-Lax
❍ Topical antibiotic cream		❍ Dextromethorphan			

Camper Medical Form *cont.*

Parent/Guardian Authorization for Healthcare:

"This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order X-rays, routine tests and treatment related to the health of my child for both routine healthcare and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for and order injection, anesthesia or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status."

Physician Authorization for Participation

"It is my professional opinion that this patient is both physically and emotionally able to participate as a camper (except as noted above)."

Physician Signature: _____ Date: _____

Physician Name (Printed): _____ Phone: _____

Physician Office Address: _____

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