Park Shore Country Day Camp

450 Deer Park Road

Dix Hills, NY 11746

631-499-8580

Email: sue@parkshoredaycamp.com

*****MUST BE COMPLETED BY PHYSICIAN ANNUALLY OR**
PROVIDE PHYSICIAN'S ANNUAL PHYSICAL EXAM & IMMUNIZATION HEALTH HISTORY FORM

Which of the following has the participant had?

____ Measles ____ Hepatitis A

____ Chicken Pox ____ Hepatitis B

____ German measles ____ Hepatitis C

____ Mumps ____ Other

TB Test: Date of last test _____

Results: ____ positive ____ negative

*Height _____ *Weight _____

*Blood Pressure _____*Pulse_____

Please give all dates of immunization for:						
Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTaP						
Tdap						
Tetanus						
Polio (OPV/IPV)						
MMR or Measles or Mumps or Rubella						
Haemophilus influenza B						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Pneumococcal vaccine						
Meningococcal vaccine						

***REQUIRED BY PHYSCIAN**

I have examined the above child and in my opinion, the above child's condition DOES_____ DOES NOT_____ preclude his/her participation in an active camp program. (Include Physician or Health Care Provider's stamp)

_____

Licensed Physician's Signature Print Name Date

Address _____ Phone _____