

**CAMP STAFF/CAMPERS MUST HAVE PHYSICAL WITHIN 24 MONTHS OF EMPLOYMENT.**

Name of Candidate: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Sex: \_\_\_\_\_ Exam Date: \_\_\_\_\_

Immunization	Date	Date	Date	Date
DPT				
DT				
Polio				
MMR				
HEP-A				
HEP-B				
Measles				
Mumps				
Rubella				
Diphtheria + Tetanus Toxoids				

TBSCREEN: Laboratory Evidence of Immunity is Acceptable \_\_\_\_\_ NO RISK \_\_\_\_\_ AT RISK \_\_\_\_\_

TB/PPD \_\_\_\_\_

CHICKENPOX? YES \_\_\_\_\_ NO \_\_\_\_\_

EXAMINATION WAS NORMAL UNLESS ABNORMALITIES LISTED BELOW

**PRIMARY CARE PHYSICIAN/PHYSICIAN RESPONSIBLE FOR THE PATIENT:**

Name of Physician: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

I \_\_\_\_\_ am covered by family medical/hospital insurance? If yes, name of the Insurance company: \_\_\_\_\_

Insurance company's address: \_\_\_\_\_ Insured's name and relation to Candidate: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_ Group ID#: \_\_\_\_\_

Candidates Signature: \_\_\_\_\_ Date: \_\_\_\_\_