

**CAMP MESORAH HEALTH HISTORY FORM / TO BE FILLED OUT BY PHYSICIAN**



CAMPER NAME: \_\_\_\_\_

**IMMUNIZATIONS** Required immunizations must be determined locally. Please record the data (month & year) of basic immunizations & most recent booster doses.

VACCINE	BASIC	BOOSTER	VACCINE	BASIC	BOOSTER
Diphtheria			Haemophilus Influenza B (HIB)		
Pertussis (Whooping Cough) DPT			Hepatitis B		
Tetanus			Injectable Polio (Salk)		
Diphtheria			Measles (Hard Measles, Red Measles, Rubella)		
Tetanus DT			Mumps		
Tetanus			Rubella (German Measles, 3 Day Measles)		
Oral Polio (Sabin) *TOPV			Tuberculin Test Given (most recent)		
Chicken Pox (Varicella)					

**ALLERGIES**

- Hay fever       Poison Ivy       Insects & Stings  
 Medication \_\_\_\_\_  Other \_\_\_\_\_

**HEALTH CARE RECOMMENDATIONS BY LICENSED PHYSICIAN**

I have examined the above camp applicant with in the past year. Date examined: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

This applicant is under the care of a physician for the following conditions:

- Epilepsy      Current Treatment: \_\_\_\_\_ Continue Treatment in Camp  Yes  No  
 Convulsions      Current Treatment: \_\_\_\_\_ Continue Treatment in Camp  Yes  No  
 Diabetes      Current Treatment: \_\_\_\_\_ Continue Treatment in Camp  Yes  No  
 ADHD      Current Treatment: \_\_\_\_\_ Continue Treatment in Camp  Yes  No  
 Eating Disorder      Current Treatment: \_\_\_\_\_ Continue Treatment in Camp  Yes  No

Current Restrictions, including dietary and activity:

\_\_\_\_\_

\_\_\_\_\_

**CURRENT MEDICATIONS:**

Name	Time	Dosage	Route	Frequency
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**ASTHMA**

Does applicant have asthma?  Yes  No      If yes,  Mild  Moderate  Severe

Maintenance Therapy while at the camp (include medications) \_\_\_\_\_

Treatment for asthma attack while at camp (nebulizers available, include medications) \_\_\_\_\_

In my opinion the above conditions  do  do not preclude his/her participation in an active camp program.

Physician Name \_\_\_\_\_ Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

**Mail this form to: Camp Mesorah 34 Parker Boulevard, Monsey, NY 10952**