TEAM PREP USA CAMP HEALTH FORM

A copy of a camper's school physical, **complete with immunization history and doctor's signature**, maybe substituted in lieu of this form if the physical was completed with 12 months of the camp start date.

Camper's Name: _____ Sex: _____ Age: _____
(Last Name) **(First Name)**

Height: _____ Weight: _____

Medical History (please check for "yes")

German Measles ☐ Measles ☐ Mumps ☐ Scarlet Fever ☐ Chicken Pox ☐
Diabetes ☐ Pneumonia ☐ Other: _____

Immunization History	**Mo./Yr.**
Small Pox Vaccine	_____
Diphtheria	_____
Tetanus Toxoid	_____
Polio Vaccine	_____
Tuberculin Test	_____
Measles	_____

Allergy History	**Yes**	**No**
Hay Fever	☐	☐
Asthma	☐	☐
Eczema	☐	☐
Hives	☐	☐
Insect Stings	☐	☐
Type _____		

Drug Reactions	**Yes**	**No**
Sulpha	☐	☐
Penicillin	☐	☐
Antibiotic	☐	☐
Type_____		

If medication will be taken during camp, indicate name of drug and dosage:

_____
_____

Please list any pertinent medical information we should have regarding past injuries, past medical history, or suggested physical limitations relating directly to the participant's ability to participate in the camp for six or more hours per day:

_____
_____
_____
_____

I certify the above-named individual is able to participate fully in the above-named activity, based on physical examination within 12 months prior to said camp date.

_____ _____
(Signature of Physician) **(Date)**

_____ _____ _____ _____
(Street Address) **(City)** **(State)** **(Zip)**