

University of Northern Colorado - Summer Enrichment Program: MEDICAL REPORT--SECTION B

For the Licensed Health Care Provider:

First Name: _____ Last Name: _____

Gender: M F Birthdate: _____

*Date of Exam: _____

(*Physical exam must be within the past year of beginning camp.)

Height: _____ Weight: _____ Blood Pressure: _____

1. Summary of health concerns: _____

2. The camper has the following medical illness(es)/conditions which are communicable or require special attention: _____

3. The camper is **ALLERGIC** to the following medications and/or substances: _____

4. Instructions for allergic reaction: _____

5. List any other specific information we should be aware of (activity or diet restrictions): _____

6. Preferred over-the-counter medication for headache/fever/pain/etc/: _____

*****Copy of Insurance card (front and back) must be attached*****

For Health Professional or Parent:

Certificate of Immunization

VACCINE	DOSES			
Diphtheria-Tetanus-Pertussis (DP or baby shots)	1 (Date)	2 (Date)	3 (Date)	4. (Date)
Tetanus-Diphtheria (TD)	1. (Date)	2 (Date)	3 (Date)	4 (Date)
Polio	1 (Date)	2 (Date)	3 (Date)	4 (Date)
Hepatitis B (HB)	1 (Date)	2 (Date)	3 (Date)	4. (Date)
Haemophilus b (Hib)	1 (Date)	2 (Date)	3 (Date)	4 (Date)
(month, day, year) Measles (Hard, Red)				
(month, day, year) Rubella (German Measles)				
(month, day, year) Mumps				
(month, day, year) Varicella (Chicken Pox)				
Pneumococcal				

MEDICATIONS CURRENTLY PRESCRIBED: Complete Form D for any and all medication (prescription/over-the-counter/vitamin/dietary and herbal supplements) to be given during camp.

To my knowledge the above information is accurate and complete.

Doctor/Health Professional Signature

Print or Stamp in addition to signature

(_____) _____

Doctor's Phone

Doctor's Address

Date

THIS FORM MUST BE COMPLETED FOR EVERY CAMPER BEFORE THEY CAN BE ADMITTED TO THE SUMMER ENRICHMENT PROGRAM AND IS ONLY EFFECTIVE DURING THE DURATION OF THE CURRENT YEAR'S PROGRAM.