

University of Massachusetts Amherst University Health Services 150 T.C. 

## **MEDICAL AND IMMUNIZATION HISTORY** PROGRAMS AND CAMPS

(413) 577-5000 / www.umass.edu/ubs    Participant name (print):    Lat  frot    Mame:  frot    Address:	HERST LED	Amherst, MA 01003-9288	3	Please return form	n to program:	
tet:    Pitt    M.     SECTION 1    (To be completed by parent or guardian.)     Sex:		(413) 577-5000 / www.un	ass.edu/uhs			
Image:  Sex:  Birth date:    Mame:  Sex:  Birth date:    Address:  City/State/Zip:    Program name:  Program dates:    Father:  Phone (day):  Phone (evening):    Guardian is:  I father  Phone (day):  Phone (evening):    Guardian is:  I father  other (name and address):  (phone number):    Emergency contact (name, phone number, relationship to participant):  Family physician name and address:    phone number:  phone number:  Sex:    Family durist  name and address:  phone number:    Family durist  name and address:  Policy number:    In case of medical emergency, I hereby give permission to University Health Services (UHS) staff to hospitalize, to secure proper treatment for, and to order injection or minor surgery for my child, as named above.    Date  Parent/guardian signature    FECTION 2  PHYSICAL EXAMINATION: Must have been done by a medical provider within the preceding 12 month    MEDICAL HISTORY (please note significant disorders):  Allergies:    Allergies:  Heart:  Tuberculosis:    MetolCAL HISTORY (please note significant disorders):  Name:    Allergies:  Lung:		Participant name (print):				
Name:  Sex:  Birth date:			Last	Fin	st	M.I.
Address:	SECTIO	N 1 (To be completed by	parent or guardian.)			
Address:	Name:			Sex:	Birth date:	
Program name:  Program dates:    Father:  Phone (day):  Phone (evening):    Guardian is:  I father  mother  Other (name and address):    (phone number):  (phone number):  (phone number):    Emergency contact (name, phone number, relationship to participant):  Phone number:  Phone number:    Family physician name and address:  phone number:  Phone number:  Phone number:    Family dentist  name and address:  Phone number:  Phone number:    Family dentist  name and address:  Phone number:  Phone number:    Family dentist  name and address:  Phone number:  Phone number:    Medical insurance company:  Policy number:  Policy number:  Phoe number:    In case of medical emergency, I hereby give permission to University Health Services (UHS) staff to hospitalize, to secure proper treatment for, and to order injection or minor surgery for my child, as named above.    ECTION 2  PHYSICAL EXAMINATION: Must bave been done by a medical provider within the preceding 12 month    MEDICAL HISTORY (please note significant disorders):  Nuerological:  Tuberculosis:						
Father:  Phone (day):  Phone (evening):    Mother:  Phone (avening):  Phone (evening):    Guardian is:  I father  mother  other (name and address):    (phone number):  (phone number):  (phone number):    Emergency contact (name, phone number, relationship to participant):						
Mother:  Phone (day):  Phone (evening):    Guardian is:  father  mother  other (name and address):    (phone number):						
Guardian is:						
(phone number):						
Family physician name and address:						
Family physician name and address:	Emergen	cy contact (name, phone nu	1			
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Phone number:	Family pl	hysician name and address:				
Family dentist  name and address:	2.1	•				
phone number:	Family de					
Medical insurance company:	,					
In case of medical emergency, I hereby give permission to University Health Services (UHS) staff to hospitalize, to secure proper treatment for, and to order injection or minor surgery for my child, as named above.     Date  Parent/guardian signature    SECTION 2  PHYSICAL EXAMINATION: Must have been done by a medical provider within the preceding 12 month    MEDICAL HISTORY (please note significant disorders):  Tuberculosis:    Allergies:  Heart:  Tuberculosis:    Diabetes:  Lung:  Varicella:    Disabilities:  Other:  Other:    Pertinent medical history:  Summary of significant treatment program, including names and doses of medications to be used while at program	Medical i					
SECTION 2  PHYSICAL EXAMINATION: Must have been done by a medical provider within the preceding 12 month    MEDICAL HISTORY (please note significant disorders):    Allergies:		to secure proper treatment		on or minor surgery	for my child, as ha	med above.
MEDICAL HISTORY (please note significant disorders):    Allergies:		Date		Parent/guardian signature		
MEDICAL HISTORY (please note significant disorders):    Allergies:	FCTIO	N 2 PHYSICAL EXAMIN	ATION Must have been	done by a medical t	rouider within the	proceeding 12 month
Allergies:  Heart:  Tuberculosis:   Kidney:  Whooping Cough:   Neurological:  Lung:  Varicella:   Neurological:  Disabilities:  Other:    Pertinent medical history:  Summary of significant treatment program, including names and doses of medications to be used while at program				i done by a medical p		
Kidney:  Whooping Cough:    Diabetes:  Lung:    Varicella:  Other:    Pertinent medical history:    Summary of significant treatment program, including names and doses of medications to be used while at program			- · ·			
Diabetes:  Lung:  Varicella:    Neurological:  Disabilities:  Other:    Pertinent medical history:  Other    Summary of significant treatment program, including names and doses of medications to be used while at program	-					
Neurological: Disabilities: Other: Pertinent medical history: Summary of significant treatment program, including names and doses of medications to be used while at program						
Pertinent medical history: Summary of significant treatment program, including names and doses of medications to be used while at program						
Summary of significant treatment program, including names and doses of medications to be used while at program	Neurolog	gical:	Disabilities:	0	ther:	
	Pertinent	medical history:				
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	(medicati	ons MUS1 be in a container	r with the original label):	:		

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Date of birth	te of birth:
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## **REQUIRED IMMUNIZATIONS** SECTION 3 **MEASLES, MUMPS AND RUBELLA (MMR) VACCINE** First dose must be after age 12 months; 2 doses required. MMR #1 \_\_\_/\_\_/ MMR #2 \_\_\_/\_\_/ **POLIO VACCINE** Dates: \_\_\_/\_\_/\_\_\_ A minimum of three doses of either inactivated polio vaccine (IPV) or oral polio \_\_\_\_/\_\_\_\_ vaccine (OPV) are required. If a mix of (IVP/OPV) was used, four doses are required. \_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_/ Completed primary series of polio immunizations? **U** YES **U** NO DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE Minimum of four doses of DTaP/DTP/DT or at least three doses of Td is required. A booster dose of Td is required for all campers and staff who will be entering grades seven through 10. For campers and staff who will be entering grades 11 and 12, a booster of Td is required if it has been more than 10 years since the last dose of DTaP/DTP/DT/Td. (Tdap is also acceptable.) Completed primary series of DTaP/DTP/DT? 🖵 YES 🗳 NO Dates: \_\_/\_/\_\_ \_/\_/\_\_ \_/\_/\_\_\_ Date last Td \_\_\_/\_\_/ **HEPATITIS B** Three doses of Hepatitis B vaccine are required if born on or after Jan. 1, 1992. Dose # 1 \_\_\_/ \_\_/ Dose #2 \_\_\_/ Dose #3 \_\_\_/ \_\_/ **EXCEPTIONS** • RELIGIOUS OBJECTION: The individual must submit a written statement, signed by a parent/guardian if a minor, to the effect that the individual is in good health and stating the reason for such objections. • MEDICAL: The individual must submit certification by a physician stating that the physical condition of the individual is such that his or her health would be endangered by such immunization. Health care provider signature and/or stamp: \_\_\_\_\_ Printed name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone:\_\_\_\_\_ Date:\_\_\_\_\_

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