University of Massachusetts Amherst
University Health Services
150 Infirmary Way
Amherst, MA 01003-9288
(413) 577-5000 / *www.umass.edu/uhs*

MEDICAL AND IMMUNIZATION HISTORY
PROGRAMS AND CAMPS

Please return form to program: _____

_____

Participant name (print): _____
Last First M.I.

SECTION 1 *(To be completed by parent or guardian.)*

Name: _____ Sex: _____ Birth date: _____
Month / Day / Year

Address: _____ City/State/Zip: _____

Program name: _____ Program dates: _____

Father: _____ Phone (day): _____ Phone (evening): _____

Mother: _____ Phone (day): _____ Phone (evening): _____

Guardian is: ❑ father ❑ mother ❑ other (name and address): _____

(phone number): _____

Emergency contact (name, phone number, relationship to participant): _____

_____

Family physician name and address: _____

phone number: _____

Family dentist name and address: _____

phone number: _____

Medical insurance company: _____ 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

SECTION 2 **PHYSICAL EXAMINATION:** *Must have been done by a medical provider within the preceding 12 months.*

MEDICAL HISTORY (please note significant disorders):

Allergies: _____ Heart: _____ Tuberculosis: _____

_____ Kidney: _____ Whooping Cough: _____

Diabetes: _____ 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 (medications MUST be in a container with the original label):

Participant name: _____ Date of birth: _____

SECTION 3 REQUIRED IMMUNIZATIONS

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? ❑ YES ❑ 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: _____