Camp Chai Medical History Form

Child Last Name: _____ Child First Name: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Birth Date: _____

Immunization History

	1 (M/D/Y)	2 (M/D/Y)	3 (M/D/Y)	4 (M/D/Y)	5 (M/D/Y)
DPT (Diphtheria, Tetanus, Pertussis)					
HIB					
Polio					
MMR (Measles, Mumps, Rubella)					
Hepatitis B					
Tetanus Booster					

TB Mantoux Test: _____ (M/D/Y) Result: ☐ Positive ☐ Negative

Medical History (please give date of last occurrence)

Chicken pox: _____ Measles: _____ Mumps: _____
Hepatitis A, B, or C: _____ Frequent ear infections: _____

Child's Physical Limitations and Special Needs

Allergies (List): _____
Routine Medications: _____
Dosage: _____ Specific times taken each day: _____
Dietary Restrictions: _____
Special Considerations (Please be Specific): _____

Parent/Guardian Signature: _____ Date: _____