**Health Care Recommendations by Licensed Medical Personnel for 4-H Camp Participants Only**

I examined this individual on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. BP\_\_\_\_\_ Wt \_\_\_\_\_ Ht\_\_\_\_\_\_

In my opinion, the above applicant 🞎 is 🞎 is not able to participate in an active camp program.

Restrictions/Recommendations:

Treatment to be continued at camp or medications to be administered at camp (name, dosage, frequency)

Additional information for health care staff at camp:

**Signature of Licensed Medical Personnel:** Date:

Printed: Title:

#### Address: Phone: (\_\_\_\_)

 *Street City State Zip Code*

Please give dates of immunizations for:

(Immunization records may be attached to this form)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Vaccine** | **Mo/Yr** | **Mo/Yr** | **Mo/Yr** | **Mo/Ry** |
| DTP |  |  |  |  |
| TD (tetanus/diphtheria) |  |  |  |  |
| Tetanus |  |  |  |  |
| Polio |  |  |  |  |
| MMR |  |  |  |  |
| Or Measles |  |  |  |  |
| Or Mumps |  |  |  |  |
| Or Rubella |  |  |  |  |
| Haemophilus influenzae |  |  |  |  |
| Hepatitis B |  |  |  |  |
| Varicella (chicken pox) |  |  |  |  |
|  |  |  |  |  |

**Screening Record: For camp use only** Date\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_

Meds received

Updates/additions to Health History

Current Health needs identified

Screened by