

Applicant's Name

Session

Birth Date

 Male  Female

# Immunization Form

HEALTH FORM 

Please complete this form and return it to the camp as soon as possible. Your Health Form will not be complete without it.

| Immunization                                   | Dose 1                          | Dose 2               | Dose 3               | Dose 4               | Dose 5               | Latest               |
|--|---------------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| DTaP or Tdap<br>Diphtheria, tetanus, pertussis | <input type="text"/><br>mm/yyyy | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |                      |
| Tetanus, Pertussis booster                     |                                 |                      |                      |                      |                      | <input type="text"/> |
| MMR<br>Mumps, measles, rubella                 | <input type="text"/>            | <input type="text"/> |                      |                      |                      | <input type="text"/> |
| IPV<br>Polio                                   | <input type="text"/>            | <input type="text"/> | <input type="text"/> | <input type="text"/> |                      |                      |
| HIB<br>Haemophilus influenzae type B           | <input type="text"/>            | <input type="text"/> | <input type="text"/> | <input type="text"/> |                      |                      |
| PCV<br>Pneumococcal                            | <input type="text"/>            | <input type="text"/> | <input type="text"/> | <input type="text"/> |                      |                      |
| Hepatitis B                                    | <input type="text"/>            | <input type="text"/> | <input type="text"/> |                      |                      |                      |
| Hepatitis A                                    | <input type="text"/>            | <input type="text"/> |                      |                      |                      |                      |
| Chicken Pox<br>Varicella                       | <input type="text"/>            | <input type="text"/> |                      |                      |                      |                      |
| MCV4<br>Meningococcal meningitis               | <input type="text"/>            |                      |                      |                      |                      |                      |

## Comments

If any of the immunizations listed above have not been received, please provide an explanation.