4 Vestal St
Nantucket, MA 02554
tel: 508.228.9198
fax: 508.228.1031

Discovery Program Health Care Record

Please submit at least 2 weeks prior to the session's start date!

Dear Parent/Guardian: If your healthcare provider has given you a form recording the most recent physical exam and all required immunizations, you can send that copy in lieu of this form. If your healthcare provider has not provided you with a form recording the most recent physical and all required immunization, please complete the information below and send this page to the provider's office to complete. Please keep a copy of this completed form for your records. Please contact the Education Director for a waiver that must be completed if the child has not had a physical exam or immunizations for religious reasons.

Camper Information:

Name: ____ ☐ Female ☐ Male ☐ Other Birth Date: ____________________

First Middle Last Month/Day/Year

Parent/ Guardian Name: ____ Parent Guardian Phone: ________________________

To the licensed medical provider: Complete this form for the camper named above. Attach any additional needed information. A copy of previously completed form from a yearly physical, or similar, may be submitted in place of this form.

Physical exam requested within **24 months** prior to camp

Physical exam done today: ☐ Yes ☐ No (If "No", date of last physical: _________________________)

Month/Day/Year

Weight: ___________lbs Height: ________ft _________ in. Blood Pressure: __________/___________

Allergies: ☐ No known allergies. ☐ This camper is allergic to (list all):

☐ Food ☐ Medicine ☐ The environment (hay fever, insect stings, etc) ☐ Other

Describe previous reactions:

If the camper has an anaphylactic allergy or asthma, include a copy of the camper's allergy and/or asthma action plan(s).

Diet and Nutrition: ☐ This camper eats a regular diet. ☐ This camper has a medically prescribed diet or dietary restrictions.

Please describe:

Medications: ☐ This camper does not take any medications. ☐ This camper takes the following medication(s).

Describe below, and include the medication name, dose, frequency, and reason for taking.

Attach additional information if needed.

Will the camper require limitations or restrictions to activity while at camp? ☐ Yes ☐ No

If "Yes", what limitations/restrictions do you recommend? Describe below. Attach additional information if needed.

Please attach additional information for camp healthcare staff if needed.

Immunization History: Provide the **day, month, and year** for each immunization. Massachusetts's requirements are listed below. Serologic proof of immunity is accepted in lieu of immunization. Campers must meet the requirements for the grade they are entering, except those entering Kindergarten may meet the Preschool requirements for summer camp. Immunizations must be recorded and signed by a licensed medical provider. The date of the last tetanus immunization is required.

Immunization [Grade(s): #doses]	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5/most recent
Diphtheria, tetanus, pertussis [DTP, DT, DTaP, Td, TdaP] [Pre, 1st-6th: 4, K: 5]					
Tetanus booster [Td, TdaP] [7th – 10th: 1]	Must be within the last 10 years				
Measles, Mumps, Rubella (MMR or MMRV) [Pre: 1, K – 12: 2]					
Polio (OPV or IPV) [Pre, 7th -12th: 3, K-6th: 4]					
Hepatitis B [Pre – 6th: 3]					

Signature of Licensed Provider: ____**Date:** ___________________________

Print Name: ___________________________________ **Title:** ________________________ **Office Phone:** ____________________

Office Address:____

Street Address City State Zip Code

THIS FORM MUST BE BOTH SIGNED AND STAMPED BY THE PROVIDER OR THE PROVIDER'S MEDICAL OFFICE