

# The Vineyard

## Health Form - Part B (Doctor's Form), 2010 Season

**RETURN TO:**  
 The Vineyard  
 1945 Vineyard Rd.  
 Westfield, NC 27053  
 USA  
 Tel: 1-336-351-2070  
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[letters@vineyardcamp.com](mailto:letters@vineyardcamp.com)  
[www.vineyardcamp.com](http://www.vineyardcamp.com)



Please have your family physician fill out this form.  
 An examination is required annually for camp registration.  
 Immunizations **MUST** be current.

Please check sessions(s) of attendance: A  B  C  D  E  F  G  H  I  J  K  L  M

Camper/Staff name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

### IMMUNIZATION HISTORY

Please record the date (MONTH and YEAR) of basic immunizations and most recent booster doses:

Vaccines	Month / Year of Basic Immunization	Month / Year of Last Booster
Diphtheria ) Pertussis (Whooping) ) Tetanus )	1) 2) 3)	1) 2)
or		
Tetanus ) Diphtheria )		
or		
Tetanus		
Oral Polio (Sabin) * TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given	(most recent)	

### Health Examination by Licensed Physician:

I have examined the above camp applicant.

(Signature) \_\_\_\_\_

Date Examined: \_\_\_\_\_

In my opinion, the above's condition does \_\_\_\_\_ / does not \_\_\_\_\_ preclude his/her participation in an active camp program.

The applicant is under the care of a physician for the following condition(s):  
 \_\_\_\_\_  
 \_\_\_\_\_

Current treatment (include current medications):  
 \_\_\_\_\_  
 \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion, or concussion:  
 \_\_\_\_\_  
 \_\_\_\_\_

Does applicant have epilepsy? Yes \_\_\_\_\_ / No \_\_\_\_\_ | Does applicant have diabetes? Yes \_\_\_\_\_ / No \_\_\_\_\_

### Recommendations and restrictions while at camp:

Any treatment to be continued at camp:  
 \_\_\_\_\_  
 \_\_\_\_\_

1. Any medication to be administered at camp ( specific dosages):

Medication must be brought in original containers

2. Any medically prescribed meal plan or dietary restrictions:  
 \_\_\_\_\_  
 \_\_\_\_\_

Any allergies (food, drugs, plants & insects, etc.):  
 \_\_\_\_\_  
 \_\_\_\_\_

LICENSED PHYSICIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Street & Number, City, State, Zip Code, Country, Phone

