# Rocky Mountain Honors CAMP

Rocky Mountain Honors Camp • P. O. Box 34 • Kiowa, CO 80117 • Phone 303-552-6537

Camp Physicals must be valid within 24 months of current camp dates.

## CAMP PHYSICAL FORM

May use either Physician's Form or this Camp Form

**Camper First/Last Name** _____

Date of Birth _____/_____/_____ Age _____ ❑Male ❑Female

Parent/Guardian _____ Phone _____

Address _____ City/St/Zip _____

| COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION | | | | | | | |
|---|---|---|---|---|---|---|---|
| Vaccine | | Enter the month, day and year each immunization was given | | | | | |
| **Hep B** | Hepatitis B | | | | | | |
| **DTaP** | Diphtheria, Tetanus, Pertussis (pediatric) | | | | | | |
| **DT** | Diphtheria, Tetanus (pediatric) | | | | | | |
| **Tdap** | Tetanus, Diphtheria, Pertussis | | | | | | |
| **Td** | Tetanus, Diphtheria | | | | | | |
| **Hib** | *Haemophilus influenzae* type b | | | | | | |
| **IPV/OPV** | Polio | | | | | | |
| **PCV** | Pneumococcal Conjugate | | | | | | |
| **MMR** | Measles, Mumps, Rubella | | | | | | |
| **Varicella** | Chickenpox | | | Healthcare Provider Documentation Date _____ | | Lab Verification Date _____ | |

**RELIGIOUS EXEMPTION:** Parent or guardian of the above-named person, or the person him/herself, is an adherent to a religious belief opposed to immunizations.

Check those that apply: ❑ **Hep B** ❑ **DTaP** ❑ **DT** ❑ **Tdap** ❑ **Td** ❑ **Hib** ❑ **IPV/OPV** ❑ **PCV** ❑ **MMR** ❑ **VAR**

Parent/Guardian Signature _____

## HEALTH HISTORY:

Is this individual taking prescription medication? ❑YES ❑NO

If yes, indicate prescription: _____

Drug Reactions: _____

Special Diet: _____

Special health/behavior needs/physical limitations: _____

Current or recent exposure to contagious/infectious disease: _____

## Medical Provider:

I have examined this camper and found him/her to be in satisfactory physical condition and capable of active participation in camping program ***except* as follows:** _____

**SIGNATURE of Physician (MD/DO, NP or PA):** X_____

**Print** Name of Medical Care Provider: _____

Office Address (city/state/zip): _____

Phone _____ **DATE OF EXAM:** _____