MIT Camp Health Form

Mail to: MIT Day Camp, 120 Vassar Street, Cambridge, MA 02139

If you are submitting your health provider's medical form, you do not need to submit this form.

Name of child: _____ Date of birth: _____

Parents' names & phone number during camp day: _____ _____

_____ _____

Other emergency contact/phone: _____

Insurance Provider and Policy Number: _____ _____

A. **Immunizations**:

1. You must supply complete dates for all required immunizations.
2. Religious exception or medical exemption from these immunizations must be documented by parent or health care professional.

Required immunizations for camp attendance:

Measles	(must be given age 1 year or older) measles vaccine, or combined MMR, 2 doses required:
Mumps	(mumps vaccine or 1 MMR):
Rubella	(rubella vaccine or 1 MMR):
Polio	(minimum 3 doses):
Tetanus	(DTP, DT, Td, DTaP: 4 doses required, plus a booster of TD if 10 years since last dose):
Hepatitis B	(series of 3; required if birthdate 1992 or later):

RECOMMENDED:

We STRONGLY urge vaccination for

Chickenpox or varicella: Had disease _____ or vaccine date _____

B. **Medication** child will be taking during the camp day: **[ ] none or:**

1. The MIT medication form must be completed and signed by health care provider (see attached):
2. Please be sure instructions are very clear: name of medication, dose and time)

_____

_____

C. **Allergies** (food, drugs, insect stings).

1. List medications, complete medications form with health care provider.

_____

_____

D. **Date of last complete physical** (must be within 24 months): _____

Signature of Health Care Professional _____

Phone number of Health Care Professional _____

1. You may supply us with a signed physical form and immunizations list, or use this form with signature of health professional.)

2. In case of emergency if parent/guardian cannot be reached, I hereby grant permission to MIT Medical Department or the local Emergency Department to provide urgent medical treatment for my child, including sutures and x-rays, if necessary.

_____ _____

Signature of Parent or Guardian Date

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / / **Sex:** ☐ **female** ☐ **male**

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, TdaP)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Other:**		
	7				
Polio (e.g., IPV, DTaP-HepB-IPV)	1				
	2				
	3				
	4				

Serologic Proof of Immunity		**Check One**	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.
Date: _____

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)* _____ **Date:** _____/_____/_____

Signature: _____

Facility Name: _____

MEDICATION ORDERS FOR MIT CAMP

TO BE FILLED OUT BY PHYSICIAN
ONLY IF CAMPER WILL BE TAKING MEDICATION WHILE AT CAMP

Medications cannot be administered at camp unless a medication order form is on file in our office. Prescription medication must be in original container, with directions printed. Medications such as acetaminophen and others bought in a drug store by parents must also have a medication administration order form on file in our office.

Name of camper: _____ Session dates: _____

1. Emergency Medications.

Inhaled Medications: _____ give 1-2 puffs: (time of camp day) _____
[ ] My child can carry and self administer this medication – if yes check box at left

Injectable Medications _____ _____

Other Medications _____ _____ _____

My child has severe allergy to: _____

Anaphylaxis Protocol (for severe reaction – short of breath, tongue/throat swelling, dizziness, vomiting)
EpiPen _____mg. Inject into outer thigh and hold for count of 6.
Benadryl _____tsp given by mouth.
[ ] Please have the counselor carry my child's EpiPen.
[ ] My child's EpiPen will be in the zipper pocket of the backpack.

2. Other Medications

These medications should be administered during the day at camp.
This includes any medications or prescriptions, such as Tylenol or Sudafed.
Medication must be labeled with camper name, with directions clearly stated.

Inhaled Medications: _____ give 1-2 puffs: (time of camp day) _____
[ ] My child can carry and self-administer this medication – if yes check box at left

Oral Medications _____ _____ _____ times/day

Nasal Medications _____ _____ _____ times/day

Other Medications _____ _____

This child's health care professional has reviewed this action plan with parent/guardian.

Signature of physician/nurse practitioner: _____

Phone number of physician/nurse practitioner: _____

Signature of parent/guardian: _____