Summer Camp Health Exam/Immunization Record

As a licensed Summer Camp with the State of Connecticut, High Hopes is required to have complete immunization history in addition to our medical history information for Summer Camp participants, volunteers and staff. This form needs to be completed, signed by a physician and returned to High Hopes. A physical examination for school purposes may also be used to satisfy this requirement provided it is dated within 36 months prior to the start of camp and includes a complete immunization history. ***If you require the administration of any medication during Summer Camp hours, please contact Sarah Carlson at High Hopes to discuss our policy. Medications including over- the- counter medication, i.e. cough drops, allergy medications, etc are prohibited without prior authorization from our staff and a written authorization form on file.***

☐ Participant ☐ Staff ☐ Volunteer

Name:____ Date of Birth: _______________Phone:_______________
Parent/Guardian:___________________________ Address:____
Emergency Contact:_____________________________________ Phone:_____________________________
Camp Session:________________________

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TO BE COMPLETED BY MEDICAL PRACTIONER

_____May participate in all camp activities
_____May participate except for:____
Medical information pertinent to routine care and emergencies:

Is this individual taking prescription medication? Yes No Explain:
If yes, indicate prescription: ____

Does the individual have allergies? Yes No Explain:
Is the individual on a special diet? Yes No Explain:

This participant/volunteer/staff is up-to-date on all the following routine childhood immunization currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

Immunization	Y	N	Date:	Immunization	Y	N	Date:
Measles				Hepatitis B			
Rubella				Mumps			
Tetanus				Chicken Pox			
Pertussis				Other:			
Polio							
Diphtheria							
Pneumococcal Conjugate							

Print name of medical care provider: ______________________________Telephone: ____________________
Medical care provider's address: ____
Medical care provider's City/Town _____________________ State: _______ Zip Code _____________
Signature of Physician, ARPN or PA ______________________________________Date: ___________________
Physical exams are valid for 3 years from the date of last examination

COMPLETED & SIGNED FORM MAY BE FAXED TO: 860-434-3723
OR MAIL TO: HIGH HOPES THERAPEUTIC RIDING
36 TOWN WOODS ROAD, OLD LYME, CT 06371
TEL: 860-434-1974