



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: _____

TO BE COMPLETED BY MEDICAL PRACTITIONER

_____ 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*