

Applicant's Name

Session

Birth Date

 Male Female

Immunization Form

HEALTH FORM 

Please complete this form and return it to the camp as soon as possible. Your Health Form will not be complete without it.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Latest
DTaP or Tdap Diphtheria, tetanus, pertussis	<input type="text"/> mm/yyyy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Tetanus, Pertussis booster						<input type="text"/>
MMR Mumps, measles, rubella	<input type="text"/>	<input type="text"/>				<input type="text"/>
IPV Polio	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
HIB Haemophilus influenzae type B	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
PCV Pneumococcal	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Hepatitis B	<input type="text"/>	<input type="text"/>	<input type="text"/>			
Hepatitis A	<input type="text"/>	<input type="text"/>				
Chicken Pox Varicella	<input type="text"/>	<input type="text"/>				
MCV4 Meningococcal meningitis	<input type="text"/>					
H1N1 Swine flu	<input type="text"/>	<input type="text"/>				
Flu shot						<input type="text"/>

If any of the immunizations listed above have not been received, please explain why. Use a second sheet if necessary.

