Camper Name: _____
Last First Middle

2019

Immunization Records, if known:	Date	Date	Date	Date	Date
DTP (Diphtheria,Tetanus and Pertussis)					
OPV (Oral Poliovirus Vaccine)					
MMR (Measles, Mumps, Rubella)					
HbPV (Haemophilus b Conjugate Vaccine)					
Tuberculin					
** **TET-TOX** (Tetanus Toxoid)					
Other:					
Other:					

***Date of last Tetanus shot , if known, is requested for all participants ** Date: _____ (MM / DD / YYYY)

STOP - THIS SECTION MUST BE FILLED OUT BY YOUR PHYSICIAN

Physicals conducted for school, sports, or yearly exams will be accepted in lieu of the one below, provided they are dated within the one (1) year span of camp attendance; must be kept current to attend camp.

Medical Exam Information - ***To be completed by a health care provider and dated within the year of camp(s) to be attended***

Blood Pressure: _____ **Weight:** _____ **Height:** _____

- Is this person able to participate in an active camp and/or recreation program? ☐ Yes ☐ No
  (Examples of camp activities include hiking, fishing, boating, swimming, dancing, field games, etc.)
- Any limitations or restrictions while at camp? ☐ Yes ☐ No If yes, describe on the line provided below:
  _____
- Any medical concerns to be monitored at camp? ☐ Yes ☐ No If yes, describe on the line provided below:
  _____
  (This includes allergies, asthma, heart conditions, blood pressure, blood sugar, weight, etc.)
- Any meal plans or dietary restrictions to be monitored at camp? ☐ Yes ☐ No If yes, describe below:
  _____
  (This includes puree, dietary supplement, food allergies and sensitivities, portion limitations, low carb, low calorie, etc.)

Comments: _____

Date of Physical Exam: _____ **Today's Date:** _____

I have reviewed the **relevant** portions of the **Camper Registration Packet** and have discussed the camp program with the camper's parent/s or guardian/s. It is my opinion that the camper is physically and emotionally fit to participate in an active camp program, except as previously noted. I am aware of all medications prescribed to this individual and see no contraindications. This person can also receive all "as needed" medications and treatments checked, or indicated on the MARS, when deemed necessary by Central Oklahoma Camp and Conference Center, Inc.

Physician's Signature/Stamp: _____

Physician's Name (please print): _____ **Phone Number:** (_____)_____-_____

Please return completed Paperwork to: Make Promises Happen, #1 Twin Cedar Lane, Guthrie, OK 73044-7041