Health Care Provider
Health Assessment Form

Please note: All health information MUST be completed and signed by your health care provider (clinic, doctor, school nurse).

Record of Immunizations:

Patient Name:____

MMR #1 (date):__________ MMR #2 (date):__________

Hep B #1 (date):__________ Hep B #2 (date):__________ Hep B #3 (date):__________

Varicella Vaccine #1 (date):__________ Varicella Vaccine #2 (date):__________

OR

Past History of Varicella (date):____________

Tetanus (date):___________
(must be within the last 10 years)

Physical examination (date):____________
(from your own health care provider or school – must be within the last 12 months)

PPD* (tuberculosis screening test):
****Contact your County Health Department or family doctor if student has not had this test in the past 2 months.***

Date Administered: ______________________ (must be within the last 2 months)
Date Read: _____________________________
Results:_________________________________

Does the student have any past history or present problems with Chicken Pox? (please describe and date):

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HEALTH CARE PROVIDER AUTHORIZATION:

The above health information is current and accurate to the best of my knowledge. I know of no reason that this individual should not participate in M.A.S.H Camp.

Provider Signature: ______________________________________Date:____________

DO NOT LEAVE ANY PART OF THIS FORM BLANK OR IT WILL NOT BE PROCESSED.