

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): _____ Date Administered: _____ (must be within the
*Contact your County Health Date Read: _____ last 2 months)
Department or family doctor Results: _____
if student has not had this test
in the past 2 months.

Flu Shot (date): _____
(must be within the 2019-2020 school year)

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

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.