IMMUNIZATIONS

Name: _____
Date of Birth: _____ ☐ Male ☐ Female
Camp Name: _____ Session: _____

Please have your child's primary healthcare provider complete this form.
You may also use an official department of health or state immunization record from your healthcare provider.

Once complete, scan and upload the document to your CampDoc.com account or return it to your camp.
Keep the original copy for your own records

Immunization History Provide the month and year for each immunization

	Dose 1 (Month/Year)	Dose 2 (Month/Year)	Dose 3 (Month/Year)	Dose 4 (Month/Year)	Dose 5 (Month/Year)
Diphtheria, tetanus, pertussis (DTaP or TdaP)	_____	_____	_____	_____	_____
Tetanus Booster (dT or TdaP)	_____				
Mumps, measles, rubella (MMR)	_____	_____			
Polio (IPV)	_____	_____	_____	_____	
Haemophilus influenzae type B (HIB)	_____	_____	_____	_____	
Pneumococcal (PCV)	_____	_____	_____	_____	
Hepatitis B	_____	_____	_____		
Hepatitis A	_____	_____			
Varicella (Chicken Pox)	_____	_____	☐ Had Chicken Pox? Date: _____		
Meningococcal meningitis (MCV4)	_____				
Seasonal Influenza	_____				
TB Test	_____	☐ Negative ☐ Positive			

If patient is **NOT** fully immunized, please sign the following statement: I understand and accept the risks to the patient from **NOT** being fully immunized.

Printed Name _____ Relationship to Patient _____ Signature _____ Date _____

Physician Authorization:

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Name of Licensed Provider _____ Signature _____ Date _____