



Cheley Colorado Camps 2020 Health Form

DUE MAY 1
Must be completed by a licensed medical professional approved to perform physical exams. Upload completed form to CampBrain account or email to Staff@Cheley.com.

Name: _____

Birthdate (DD/MM/YYYY): _____

Male Female First Term Second Term Staff

To be completed by physician:

Date of last physical exam: _____ Height: _____ Weight: _____ Blood Pressure: _____

Conditions

List conditions for which the patient is receiving treatment

Treatments/Medications

List treatments/meds to be used at camp: name/dose/frequency

Restrictions: List activity restrictions

Diet/Nutrition: List dietary restrictions

Past Medical/Surgical History

Allergies: List all allergies and reactions

Physician Authorization: I have reviewed the patient health history and have discussed the camp program with the parent/guardian. I find the patient physically/emotionally fit to participate in an active camp program, except as noted above.

Name: _____

Signature: _____

Address: _____ City: _____ State: _____ Zip: _____

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com



COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____

Date of birth: _____

Parent/guardian: _____

Required vaccines

Immunization date(s) MM/DD/YY

Titer date*
MM/DD/YY

Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib <i>Haemophilus influenzae</i> type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease	Varicella - positive screen date
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*A positive laboratory titer report must be provided to the school to document immunity.

*The shaded area under "Titer date" indicates that a titer is not acceptable proof of immunity for this vaccine.

Recommended vaccines

Immunization date(s) MM/DD/YY

HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: _____

Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____

Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____