

Applicant's Name

Session

Birth Date

 Male  Female

# Immunization Form

HEALTH FORM 

Please complete this form and return it to the camp as soon as possible. Your Health Form will not be complete without it.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Latest
DTaP or Tdap Diphtheria, tetanus, pertussis	<input type="text"/> mm/yyyy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Tetanus, Pertussis booster						<input type="text"/>
MMR Mumps, measles, rubella	<input type="text"/>	<input type="text"/>				<input type="text"/>
IPV Polio	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
HIB Haemophilus influenzae type B	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
PCV Pneumococcal	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Hepatitis B	<input type="text"/>	<input type="text"/>	<input type="text"/>			
Hepatitis A	<input type="text"/>	<input type="text"/>				
Chicken Pox Varicella	<input type="text"/>	<input type="text"/>				
MCV4 Meningococcal meningitis	<input type="text"/>					
H1N1 Swine flu	<input type="text"/>	<input type="text"/>				
Flu shot						<input type="text"/>

If any of the immunizations listed above have not been received, please explain why. Use the other side if necessary.