

Girl Scouts of Rhode Island
Immunization and Physical Exam Form
Summer Camp
To Be Completed By Physician

Camper Name: _____ Date of Birth: _____ Age: _____

Health Care Provider Name and Address: _____

Immunization Record: The immunizations listed below are required by GSRI in order to participate in summer camp program.

Immunization	Date	Date	Date	Date	Date
Hepatitis	1.	2.	3.	N/A	N/A
DTP/DTaP	1.	2.	3.	4.	5.
Td	1.	2.	3.	4.	5.
Polio OPV/IPV	1.	2.	3.	4.	N/A
Measles/Mumps/ Rubella MMR	1.	2.	3.	N/A	N/A
Varicella (chicken pox)	1.	2.	____ History of Disease ____/____/____		

Physical Examination: Camper must have a record of a physical exam within 2 years of camp dates.

Date of last exam: ____/____/____ Height: _____ Weight: _____ BP: ____/____

Asthma : ____ No ____ Yes Diabetes: ____ No ____ Yes Allergies: ____ No ____ Yes

If yes, please explain and list treatment: _____

Relevant past medical treatment: _____

Medication required: ____ No ____ Yes (*Please list*): _____

Restrictions: Is able to participate in physical activities: ____ Fully ____ with limitations

Please note any health problem, dietary restriction, chronic health condition or disability that may affect health or behavior at camp: _____

Health Care Provider Signature: _____ Date: _____

Licensed Physician