PHYSICIAN'S STATEMENT OF HEALTH & IMMUNIZATION FORM

For the protection of all Mass Athlete Performance, participants and staff, we ask that a Statement of Health and Immunization Form be completed by your child's Physician before your child can participate in the MAP program. You may submit this form to your child's Physician to complete, or have your child's Physician submit their own form. Each child must have a physical within 18 months of the start of camp.

You must bring to registration or email to docs@massathlete.com prior to participation.

Participants Name: ______________________________________ Gender: _______

Date of Birth: _______________

Blood Pressure: _______________ Height: _______ Weight: ___________

Immunization History:

Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Month/ Year	Month/ Year	Month/ Year	Month/ Year	Month/ Year
DPT (Diphtheria, Pertussis, Tetanus)					
TD (Tetanus, Diptheria)					
Tetanus					
Polio					

MMR (Measles, Mumps, Rubella)					
Hepatitis B					
Varicella (Chicken Pox)					
Hib (Haemophilus influenza)					
Tuberculin Test Results					
Lead Test Results					
Other					

Check if normal or give details:

Eyes _______________Vision _______________ Skin________________ Throat ______________

Ears _____________

Hearing____________ Teeth _______________ Heart_______________ Lungs ______________

Posture___________

Musc/Skel __________ CNS ________________ Hernia ______________ Abdomen

____

Genetalia ____________ Menstruation _____________

Known Allergies and Treatment:

Food ____

Medication(s) ____

Environment ___________________________________ Insect(s)_________________

Is the person currently under the care of a physician? Yes: ____ No: ____

If yes, why? _______________________

Current medications or treatment

____

Recommend/describe any limitations or restrictions on activities:

____

Medications to be taken/administered: (including sunscreen, inhalers, etc.) Please list ALL prescription medication, and any over-the-counter or nonprescription drugs, taken routinely.

Name of Medication(s):

____

Additional health information:

____

I have examined this child herein described and it is my opinion that this child is able to engage in and participate in all program activities, unless otherwise noted above.

Licensed Physician's Signature: ____________________________________

Telephone: _________________

Address: ____

Examination Date: __________________________