Cheley Colorado Camps
2018 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 physical exam: _______________ Height: _________ Weight: _________ Blood Pressure: ___________

Conditions

List conditions for which the patient is receiving treatment

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____

Treatments/Medications

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

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Restrictions: List activity restrictions

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____

Diet/Nutrition: List dietary restrictions

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Past Medical/Surgical History

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Allergies: List all allergies and reactions

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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: __________

*Cheley Colorado Camps * Phone: (303) 377-3616*

*Winter (Until May 15): PO Box 6525, Denver, CO 80206 * Summer: PO Box 1170, Estes Park, CO 80517*

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

Vaccine							Titer date* MM/DD/YY
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* 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	

*A positive laboratory titer report must be provided to the school to document immunity.

Recommended vaccines

Immunization date(s) MM/DD/YY

Vaccine							
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: __________

Last Reviewed: December 2017