Camp Strong4Life
Camper Immunization Form

Provide the month and year for each immunization. **Copies of immunization forms from healthcare providers or state or local government (Form 3231) are preferred; please attach them to this form.**

Camper Name: _____ **DOB:** ___/___/___

Parent/Guardian Name: _____ **Relationship to Camper:** _____

Immunization	Dose 1 (mm/yy)	Dose 2 (mm/yy)	Dose 3 (mm/yy)	Dose 4 (mm/yy)	Dose 5 (mm/yy)	Most Recent Dose (mm/yy)
Diphtheria, tetanus, pertussis* (DTaP or Tdap)						
Tetanus booster (Td or Tdap)						
Mumps, measles, rubella (MMR)*						
Haemophilus influenzae type b (Hib)						
Polio (IPV)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella* (chicken pox) or history of disease: ❍N ❍Y; date:						
Meningococcal meningitis (MCV4)						
Influenza						
COVID-19 (recommended)						

I verify that all of the dates above are correct.

Signature of Parent/Guardian: _____ Date: _____

Email or fax a copy of the Immunization Form to Camp Strong4Life.

Email: CampStrong4Life@choa.org **Fax:** 404-785-3241

Camp Strong4Life Medical Form

This form is to be completed by a licensed clinician.
Examination required between June 6, 2025, and May 30, 2026.

Patient Information		
Name:	DOB:	Biological Sex: ❍M ❍F
Pediatrician Office:	Pediatrician Office Phone:	Date of Last Exam:
Height:	Weight:	B/P:

Medical Information
Fill in below using code: (S) Satisfactory or (NS) Not Satisfactory. **If NS is selected, explain abnormal findings.**

Extremities:	❍S ❍NS; explain:
Throat:	❍S ❍NS; explain:
Nose:	❍S ❍NS; explain:
Heart:	❍S ❍NS; explain:
Skin:	❍S ❍NS; explain:
Lungs:	❍S ❍NS; explain:
Eyes:	❍S ❍NS; explain:
Ears:	❍S ❍NS; explain:

Patient Health History
Fill in below using code: (N) No or (Y) Yes. **If Y is selected, explain condition.**

Heart Defect/Disease:	❍N ❍Y; explain:
Tuberculosis:	❍N ❍Y; explain:
Asthma:	❍N ❍Y; explain:
Sleep Apnea:	❍N ❍Y; explain: If yes, does patient use a CPAP machine? ❍N ❍Y
Pre-Diabetes:	❍N ❍Y; explain:
Diabetes Type 1:	❍N ❍Y; explain:
Diabetes Type 2:	❍N ❍Y; explain:
Recent Hospitalization:	❍N ❍Y; explain:
ADD/ADHD:	❍N ❍Y; explain:
Depression:	❍N ❍Y; explain:
Anxiety:	❍N ❍Y; explain:
Autism:	❍N ❍Y; explain:
Other Diseases/Conditions:	❍N ❍Y; explain:

Is the patient under the care of a clinician for any conditions (e.g., gastroenterologist, pulmonologist, behavioral/mental health specialist, urologist, endocrinologist)? ❍Y ❍N If yes, explain:

Do you feel that the patient has **physical** limitations or disabilities that would limit their participation at camp?
❍Y ❍N If yes, explain:

Do you feel that the patient has **cognitive, emotional or behavioral** limitations or disabilities that would limit their participation at camp? ❍Y ❍N If yes, explain:

Camper Medical Form *cont.*

Patient Allergies Fill in below using code: (N) No or (Y) Yes. **If Y is selected, explain allergic reaction (hives, anaphylaxis, etc).**	
Hay Fever:	❍N ❍Y; explain:
Bee Stings:	❍N ❍Y; explain:
Oak/Ivy Poisoning:	❍N ❍Y; explain:
Seasonal:	❍N ❍Y; explain:
Medications:	❍N ❍Y; explain:
Foods:	❍N ❍Y; explain:

Parent/Guardian Authorization for Healthcare:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining clinician. I give permission to the clinician selected by the camp to order X-rays, routine tests and treatment related to the health of my child for both routine healthcare and in emergency situations. If I cannot be reached in an emergency, I give my permission to the clinician to hospitalize, secure proper treatment for and order injections, anesthesia or surgery for this child. I understand the information on this form will be shared on a need-to-know basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health records from providers who treat my child, and these providers may talk with the program's staff about my child's health status.

Signature of Parent/Guardian: _____ Date: _____

Clinician Authorization for Participation

It is my professional opinion that this patient is **physically, cognitively** and **emotionally** able to participate as a camper (except as noted above).

Clinician Signature: _____ Date: _____

Clinician Name (Printed): _____ Phone: _____

Clinician Office Address: _____

Email or fax a copy of the Medical Form to Camp Strong4Life.

Fax: 404-785-3241

Email: CampStrong4Life@choa.org