

**THAYER ACADEMY SUMMER SPORTS CAMPS  
Medical Report of Physical Exam and Immunizations**

**\*NOTE: An Equivalent Form (Provided by your Physician) May Be Used in Place of This Form.**

Student Name: \_\_\_\_\_ Last First  Male  Female Date of Birth: \_\_\_/\_\_\_/\_\_\_  
MO. DAY YR.

**I. IMMUNIZATIONS**

<b>Hepatitis B</b>		<b>MMR</b>	
<input type="checkbox"/> 3-dose or <input type="checkbox"/> 2-dose series DATE 1 ___/___/___ 2 ___/___/___ 3 ___/___/___	<input type="checkbox"/> Serologic Proof of Immunity DATE ___/___/___	DATE 1 ___/___/___ 2 ___/___/___	<input type="checkbox"/> Serologic Proof of Immunity DATE <input type="checkbox"/> Measles ___/___/___ <input type="checkbox"/> Mumps ___/___/___ <input type="checkbox"/> Rubella ___/___/___
<b>DTaP/DTP/DT</b>		<b>Varicella</b>	
<input type="checkbox"/> DTaP/DTP or <input type="checkbox"/> DT 1 DATE ___/___/___ <input type="checkbox"/> DTaP/DTP or <input type="checkbox"/> DT 2 ___/___/___ <input type="checkbox"/> DTaP/DTP or <input type="checkbox"/> DT 3 ___/___/___ <input type="checkbox"/> DTaP/DTP or <input type="checkbox"/> DT 4 ___/___/___ <input type="checkbox"/> DTaP/DTP or <input type="checkbox"/> DT 5 ___/___/___		DATE 1 ___/___/___ 2 ___/___/___ <input type="checkbox"/> Serologic Proof of Immunity DATE ___/___/___	
<b>Polio</b>		<b>Chickenpox History</b>	
<input type="checkbox"/> IPV or <input type="checkbox"/> OPV 1 DATE ___/___/___ <input type="checkbox"/> IPV or <input type="checkbox"/> OPV 2 ___/___/___ <input type="checkbox"/> IPV or <input type="checkbox"/> OPV 3 ___/___/___ <input type="checkbox"/> IPV or <input type="checkbox"/> OPV 4 ___/___/___ <input type="checkbox"/> IPV or <input type="checkbox"/> OPV 5 ___/___/___		DATE ___/___/___ Check the box if this person has a physician-certified reliable history based on: - physician interpretation of parent/guardian description of chickenpox; or - physician diagnosis of chickenpox.	
		<b>HIB (Preschool only)</b>	<b>TB Risk Screening</b>
		DATE DATE 1 ___/___/___ 3 ___/___/___ 2 ___/___/___ 4 ___/___/___	<input type="checkbox"/> Low Risk: PPD not required <input type="checkbox"/> High Risk: PPD required DATE (mm) PPD: ___/___/___ Results: Neg Pos ___ Follow-up: _____
		<b>Lead Screening (Kindergarten only)</b>	
		DATE ___/___/___ Level: _____	

**II. MEDICAL HISTORY**

Allergies: \_\_\_\_\_  
 \_\_\_\_\_  Requires EpiPen

Medical conditions: \_\_\_\_\_  
 \_\_\_\_\_

Mental health concerns: \_\_\_\_\_

Current medications: \_\_\_\_\_  
 \_\_\_\_\_

**III. PHYSICAL EXAM**

Date of exam: \_\_\_/\_\_\_/\_\_\_  WNL (unless noted below)

Height: \_\_\_\_\_ inches; Weight: \_\_\_\_\_ pounds; P: \_\_\_\_\_; BP: \_\_\_\_\_

Vision: Left \_\_\_\_\_ Right \_\_\_\_\_  Glasses/Contacts

Hearing: Left \_\_\_\_\_ Right \_\_\_\_\_

Postural:  WNL;  Abnormal \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_

**IV. MEDICAL CLEARANCE**

Based on the physical exam and medical assessment, noted above, the student may participate in all physical activities and sports

without restriction, or  with the following restriction(s): \_\_\_\_\_

Physician or  PNP: (Print Name) \_\_\_\_\_ (Signature) X \_\_\_\_\_

Facility: \_\_\_\_\_ Address: \_\_\_\_\_

Office Tel #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_ Date of form completion: \_\_\_/\_\_\_/\_\_\_