

ALLERGIES: _____

IMMUNIZATION RECORD

VACCINES

Does camper have current vaccines? YES _____ NO _____

Tetanus YES _____ DATE _____

COVID Date of shot #1 _____ Date of shot #2 _____

Date of Booster _____ Manufacturer _____

Important: Please notify the camp if the leader is exposed to any communicable disease during the three weeks prior to camp.

If the leader has ANY classic COVID symptoms: Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea – DO NOT come to camp as we will send the leader home immediately.

I give permission for Camp Tamarack personnel to administer the following non-prescription medication to the leader as needed. Dosage will be based on age and weight. Please cross out any items, which are not acceptable.

Acetaminophen or Ibuprofen
Antibiotic ointment

Sore throat lozenges
Benadryl topical ointment
Benadryl oral

Calamine lotion
Anti-Itch ointment

I also give permission to the physician selected by the camp to order x-rays, routine tests and treatment for the health of the above named camper. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the above named camper.

I understand that the camp does not carry health/accident insurance and I accept responsibility for the cost of any medical care provided whether or not it is covered by my family medical/hospital insurance.

I also give my permission for the use of pictures including above leader to be used in promotional camping displays and brochures, without monetary reimbursement.

I certify that the information in this Health History is correct.

Leader or Parent/Guardian Signature Date _____