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 www.beaverbrook.org

**Immunizations and Infectious Disease History
 To be Completed and Signed by Physician within the Last 2 years**

All information will be kept confidential. BBA does not retain forms from previous years.

Child's Name: _____ Sex: Male Female
 Date of Birth: _____ Age on 9/30/18: _____ Home Phone #: _____

Vaccine	Date of Basic Immunization	Year of Last Booster	Date of Illness
DPT (Diphtheria, Perrussis, Tetanus)			
Tdap (Tetanus, Diphtheria)			
Tetanus			
IPV (inactivated Polio)			
MMR (Measles, Mumps, Rubella)			
Hib (Haemophilus influenza type B)			
Meningococcal Vaccine (by Gr. 7)			
Hepatitis B			
Varicella (Chicken Pox)			

PHYSICIAN'S STATEMENT

"I have examined the above child within the past two years. In my opinion, the child's condition does not preclude his or her participation in an active camp program."

 Physician's Signature

 Date of Form Completion

Date of Child's Last Exam: _____