

**Girl Scouts of Rhode Island**  
**Immunization and Physical Exam Form**  
**Summer Camp**  
*To Be Completed By Physician*

Camper Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Health Care Provider Name and Address: \_\_\_\_\_

**Immunization Record:** The immunizations listed below are required by GSRI in order to participate in summer camp program.

Immunization	Date	Date	Date	Date	Date
Hepatitis	1.	2.	3.	N/A	N/A
DTP/DTaP	1.	2.	3.	4.	5.
Td	1.	2.	3.	4.	5.
Polio OPV/IPV	1.	2.	3.	4.	N/A
Measles/Mumps/ Rubella MMR	1.	2.	3.	N/A	N/A
Varicella (chicken pox)	1.	2.	____ History of Disease ____/____/____		

**Physical Examination:** Camper must have a record of a physical exam within 2 years of camp dates.

Date of last exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_/\_\_\_\_

Asthma : \_\_\_\_ No \_\_\_\_ Yes Diabetes: \_\_\_\_ No \_\_\_\_ Yes Allergies: \_\_\_\_ No \_\_\_\_ Yes

If yes, please explain and list treatment: \_\_\_\_\_

Relevant past medical treatment: \_\_\_\_\_

Medication required: \_\_\_\_ No \_\_\_\_ Yes (*Please list*): \_\_\_\_\_

Restrictions: Is able to participate in physical activities: \_\_\_\_ Fully \_\_\_\_ with limitations

Please note any health problem, dietary restriction, chronic health condition or disability that may affect health or behavior at camp: \_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Licensed Physician*