



FISHKILL RECREATION

793 Route 52, Fishkill, NY 12524 ~ tel. 845.831.3371 ~ fax 845.831.3169 ~ www.fishkillrecreation.com

Updated Immunization Record

Campers who submitted Immunization Records in 2008 or 2009 do not need to submit new forms unless the camper has had updated Immunizations since then. We have no records prior to 2008. Anyone who submitted Immunization forms in 2007 or before ***must*** submit new Immunization this year, as required by the Board of Health.

All paperwork must be completed and received no later that June 12, 2010.

If these records are not returned to Fishkill Recreation, your child may lose their place at Summer Camp.

Camper's Name _____ D.O.B _____ Camp _____

Please give all dates of Immunization for OR attach a photocopy of Official Records:

VACCINE	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	/	/	/	/	/	/
TD	/	/	/	/	/	/
Tetanus	/	/	/	/	/	/
Polio	/	/	/	/	/	/
MMR	/	/	/	/	/	/
<i>Or Measles</i>	/	/	/	/	/	/
<i>Or Mumps</i>	/	/	/	/	/	/
<i>Or Rubella</i>	/	/	/	/	/	/
HiB*	/	/	/	/	/	/
HepB	/	/	/	/	/	/
Varicella	/	/	/	/	/	/

** Although HiB is not required for school, it is a **Mandatory Immunization** to attend Camp.*

Which of the following diseases has your child has? Circle all that apply.

Measles	Hepatitis
Chicken Pox	Tuberculosis
German Measles	Rheumatic Fever
Mumps	

Restrictions

Explain any physical, emotional or mental restrictions to activity
(e.g. what cannot be done, what adaptation or limitations are necessary).



Medication Form

Individualized Orders for:

Camper's Name _____

D.O.B _____ Camp _____

If your child is currently taking medication, please complete the rest of this page and have it signed by your child's physician. Your child will not be allowed to attend camp without it.

*This form **must** be completed for any camper currently taking medication. Campers taking any prescription medications while at camp must be able to self-administer the medication under the supervision of the Camp Health Director. The Camp Health Director is only permitted to dispense medications that are listed on this form by the child's doctor.*

Physician's Name _____ Phone _____

Address _____ License No, _____

Signature (not Stamped) _____ Date / /

PERSCRIPTION MEDICATIONS

Please complete the table below with the patient's current medication regimen for both scheduled and PRN medications (this includes Epi-Pens, Ritalin, etc.):

Drug Name	Route	Dosage and Schedule	Indications	Camper HealthCare Provider Order	Comments	At Home	At Camp

SEE OTHER SIDE: