

2025 CAMP WHIRLYGIG – PHYSICIAN'S FORM

CAMPER'S FULL NAME _____ CAMPER'S DOB _____

PARENT / GUARDIAN FULL NAME _____

This form must be completed and on file at the camp for any child to attend. Include the month and year of all vaccinations.

Immunization History
DTap/Tdap*
Polio*
Hep B*
MMR*
Chicken Pox (Varicella)*
TB
Influenza A
Haemophilus Influenza B (Hib)
Covid-19
Allergies
TB Risk Assessment
Current Health Issues
Medications
The signature on this form verifies that the above named individual has no restrictions on activity.

The above information is required by board of health regulation 105 CMR 430.151 for any camper attending a day camp in Massachusetts. (* indicates those vaccines that are required by state regulation to attend camp. Vaccines not marked with an * are optional.) If additional space is needed to answer any of the above fields, please attach a second page.

Physician's Name and Contact Information

Name: _____ Practice Name: _____

Address: _____ Phone Number: _____

Board of health regulation 105 CMR 430.151 allows for this form to be completed by either the camper's physician or a parent / guardian. You may also attach a copy of any immunization record or school or camp health form that the physician already provides if one is accessible to you.

Parent/Guardian Signature: _____ **Date:** _____

or

Physician's Signature: _____ **Date:** _____