

IMMUNIZATION HISTORY

Required immunizations must be determined locally. This is a record of dates of basic immunizations and most recent booster doses.

DTP Series _____ Booster _____ Tetanus Booster _____
Polio OPV (Sabin) _____ Booster _____ Typhoid _____
Measles Vaccine (live) _____ Tuberculin Test _____
German Measles (Rubella) _____ Mumps Vaccine (live) _____
Smallpox _____ Hep A _____ Hep B _____

MEDICAL EXAMINATION-- To be filled out by licensed physician.

This examination should be performed within 1 year of participation in the OWA expedition, trip, camp or other event. Examination for some other purposes within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Code: OK --Satisfactory X-- Not Satisfactory (explain) N/A-- Not Determined

Height _____ Weight _____ B.P. _____ Urinalysis _____
Pulse _____ Respirations _____
Eyes _____ Glasses _____ Extremities _____
Posture (spine) _____ Ears _____ Skin _____
Nose _____ Throat _____ Teeth _____
Allergy (Please Specify) _____ Abdomen _____
Heart _____ Lungs _____ Hernia _____

General Appraisal: _____

(For Females)

Has this person menstruated? _____ If not, has she been told about it? _____
If so, is her menstrual history normal? _____ Special Considerations: _____

Recommendations and restrictions while participating in an OWA program:

Special Diet _____

Special Medicine (name it) _____ Is parent sending it? _____

Swimming _____ Strenuous Activity _____

Other _____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in OWA camp, program, expedition, and event activities, except as noted above.

Examining Physician: _____ M.D.

Phone _____ Address _____

Date _____