



## F.A.C.T. - CAMP GONNAWANNAGOAGIN' HEALTH FORM

### Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering day care. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Camper's Name: \_\_\_\_\_

Camper's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex: \_\_\_\_\_ State or Country of Birth: \_\_\_\_\_ Middle Main Language Spoken: \_\_\_\_\_

Camper's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Parent or Legal Guardian 1: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Parent or Legal Guardian 2: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work or Cell: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): \_\_\_\_\_

List all prescription, over-the-counter, and herbal medications your child takes regularly:

Check here if you want to discuss confidential information with the camp director or other camp authority.  Yes  No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance: \_\_\_\_\_ None \_\_\_\_\_ FAMIS Plus (Medicaid) \_\_\_\_\_ FAMIS \_\_\_\_\_ Private/Commercial/Employer sponsored

**I, \_\_\_\_\_ (do \_\_\_) (do not \_\_\_) authorize my child's health care provider and designated provider of health care in the day care setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your daycare provider. When information is released from your child's record, documentation of the disclosure is maintained in your child's health record.**

**Signature** of Parent or Legal Guardian: \_\_\_\_\_ **Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Signature** of person completing this form: \_\_\_\_\_ **Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**F.A.C.T. - CAMP GONNAWANNAGOAGIN'  
HEALTH FORM  
Part II - Certification of Immunization**

*Section I*

**To be completed by a physician or his designee, registered nurse, or health department official.  
See Section II for conditional enrollment and exemptions.**

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.  
Only vaccines marked with an asterisk are currently required for camp entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Camper's Name: _____		Date of Birth:  ____   ____   ____			
<i>Last</i>		<i>First</i>		<i>Middle</i>	
<i>Mo.</i>		<i>Day</i>		<i>Yr.</i>	
IMMUNIZATION	1	2	3	4	5
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)					
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)					
*Tdap booster (6 <sup>th</sup> grade entry)					
*Poliomyelitis (IPV, OPV)					
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age					
*Pneumococcal (PCV conjugate) *only for children <60 months of age					
Measles, Mumps, Rubella (MMR vaccine)					
*Measles (Rubeola)			Serological Confirmation of Measles Immunity:		
*Rubella			Serological Confirmation of Rubella Immunity:		
*Mumps					
*Hepatitis B Vaccine (HBV) <input type="checkbox"/> Merck adult formulation used					
*Varicella Vaccine			Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine					
Meningococcal Vaccine					
Human Papillomavirus Vaccine					
Other					
Other					

I certify that this child is ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED in accordance with the MINIMUM requirements for attending school, child care, day care or preschool prescribed by the State Board of Health's Regulations for the Immunization of School Children (Reference Section III).

**Signature of Medical Provider or Health Department Official:** \_\_\_\_\_ **Date (Mo., Day, Yr.):** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Camper's Name: \_\_\_\_\_ Date of Birth: |\_\_|\_|\_|

**Section II**  
**Conditional Enrollment and Exemptions**

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

**MEDICAL EXEMPTION:** As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this child's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

\_\_\_\_\_  
\_\_\_\_\_

DTP/DTaP/Tdap:[\_\_]; DT/Td:[\_\_]; OPV/IPV:[\_\_]; Hib:[\_\_]; Pneum:[\_\_]; Measles:[\_\_]; Rubella:[\_\_]; Mumps:[\_\_]; HBV:[\_\_]; Varicella:[\_\_]

This contraindication is permanent: [\_\_], or temporary [\_\_] and expected to preclude immunizations until: Date (Mo., Day, Yr.): |\_\_|\_|\_|.

**Signature of Medical Provider or Health Department Official:** \_\_\_\_\_ **Date (Mo., Day, Yr.):** |\_\_|\_|\_|

**RELIGIOUS EXEMPTION:** The *Code of Virginia* allows a child an exemption from receiving immunizations required for day care attendance if the child or the child's parent/guardian submits an affidavit to the day care's admitting official stating that the administration of immunizing agents conflicts with the child's religious tenets or practices. Any child entering day care must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office, day care admin office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

**CONDITIONAL ENROLLMENT:** As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending daycamp and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on \_\_\_\_\_.

**Signature of Medical Provider or Health Department Official:** \_\_\_\_\_ **Date (Mo., Day, Yr.):** |\_\_|\_|\_|

**Section III**  
**Requirements**

**For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at <http://www.vdh.virginia.gov/epidemiology/immunization>**

**Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).  
(Requirements are subject to change.)**

**Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT**

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into Camp Gonnawannagoagin'.

Camper's Name: \_\_\_\_\_

Date of Birth:    /    /

Sex:  M  F

<b>Health Assessment</b>	<b>Date of Assessment:</b> ____ / ____ / ____ Weight: _____ lbs. Height: ____ ft. ____ in. Body Mass Index (BMI): _____ BP _____ <input type="checkbox"/> Age / gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided	<b>Physical Examination</b> 1 = Within normal    2 = Abnormal finding    3 = Referred for evaluation or treatment <table style="width:100%; border:none;"> <tr> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> </tr> <tr> <td>HEENT</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Neurological</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Skin</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Abdomen</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Genital</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Heart</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Extremities</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Urinary</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		1	2	3		1	2	3		1	2	3	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		1	2	3		1	2	3		1	2	3																																						
	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																						
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
<b>TB Screening:</b> <input type="checkbox"/> No risk for TB infection identified <input type="checkbox"/> No symptoms compatible with active TB disease <input type="checkbox"/> Risk for TB infection or symptoms identified <b>Test for TB Infection: TST IGRA Date:</b> _____ <b>TST Reading</b> _____ mm <b>TST/IGRA Result:</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <b>CXR required if positive test for TB infection or TB symptoms.    CXR Date:</b> _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal																																																		

<b>Developmental Screen</b>	<i>Assessed for:</i>	<i>Assessment Method:</i>	<i>Within normal</i>	<i>Concern identified:</i>	<i>Referred for Evaluation</i>
	Emotional/Social				
	Problem Solving				
	Language/Communication				
	Fine Motor Skills				
	Gross Motor Skills				

<b>Hearing Screen</b>	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.				<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Unable to test – needs rescreen <input type="checkbox"/> Permanent Hearing Loss Previously identified:    ___Left    ___Right <input type="checkbox"/> Hearing aid or other assistive device
		1000	2000	4000	
	R				
	L				
<input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Refer					

<b>Vision Screen</b>	<input type="checkbox"/> With Corrective Lenses (check if yes)				
	Stereopsis	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Not tested	
	Distance	Both	R	L	Test used:
		20/	20/	20/	
<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> Unable to test – needs rescreen					

<b>Dental Screen</b>	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
----------------------	--

<b>Recommendations to Child Care, or Day Camp Personnel</b>	<b>Summary of Findings</b> (check one): <input type="checkbox"/> Well child; no conditions identified of concern to day camp program activities <input type="checkbox"/> Conditions identified that are important to day camp or physical activity (complete sections below and/or explain here): _____ _____ _____	
	___ <b>Allergy</b> <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____ Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction    Response required: <input type="checkbox"/> none <input type="checkbox"/> epinephrine auto-injector <input type="checkbox"/> other: _____	
	___ <b>Individualized Health Care Plan needed</b> (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)	
	___ <b>Restricted Activity</b> Specify: _____	
	___ <b>Developmental Evaluation</b> <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____	
	___ <b>Medication.</b> Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at day care.	
	___ <b>Special Diet</b> Specify: _____	
	___ <b>Special Needs</b> Specify: _____	
___ <b>Other Comments:</b> _____		

<b>Health Care Professional's Certification</b> (Write legibly or stamp) <input type="checkbox"/> By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).		
Name: _____	Signature: _____	Date: ____ / ____ / ____
Practice/Clinic Name: _____	Address: _____	
Phone: _____	Fax: _____	Email: _____

