

**Summer Adventure Camp 2010**  
**10555 Spring Cypress**  
**Houston, TX 77070**  
**281-378 4080 (Fax: 281-378 4081)**

**If your child's vaccination record and Statement of Health (signed by a health care professional) is currently on file with The Adventure Programs then you only need to complete the upper and lower parts of this form, sign & date.**

**Health Form**

**Child's Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (Last) (First) (Middle) mo / day / yr

**Doctor's Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Contagious Diseases:** (check the ones that the child has had)

Measles (Rubeola)  Mumps  Rubella  Chicken Pox  Scarlet Fever  others (list) \_\_\_\_\_

**Immunization Dates (mo/day/yr)**

**Already on file at The Adventure Programs: Yes No**

	1	2	3	4	5
DTP/DTa	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
IPV/OPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
MMR:	___/___/___	___/___/___	___/___/___		
HepB:	___/___/___	___/___/___	___/___/___	___/___/___	
HiB:	___/___/___	___/___/___	___/___/___	___/___/___	
Varicella	___/___/___	___/___/___	Or Date of Disease	___/___/___	
Me:	___/___/___	Mu: ___/___/___	Ru: ___/___/___	MR: ___/___/___	
Td:	___/___/___	___/___/___	___/___/___		
Influenza	___/___/___	___/___/___			
HepA:	___/___/___	___/___/___			
Pneumococc:	___/___/___	___/___/___	___/___/___		Roto: ___/___/___

**Has your child had any operations?** (If so, list date and information): \_\_\_\_\_

**Does your child have any allergies?** (If yes, please fill in enclosed allergy card): \_\_\_\_\_

**Has your child ever had any developmental problems?** (Speech, hearing, etc.) \_\_\_\_\_

**Other information about your child's health that might be helpful:** \_\_\_\_\_

**To my knowledge, this child is free from any communicable disease:** \_\_\_\_ yes \_\_\_\_ no

**Health Care Professional's Statement:** I have examined the above named child within the past year and find that he/she is physically able to take part in the child- care program.

\_\_\_\_\_  
 Parent's Signature Date Health Care Professional's Signature Date

**A Statement of Health is required for each child enrolled in the program each year. Your Health Care Professional's form and a copy of the child's shot record may be attached to this form. (This form must still be completed by the parent.) The shot record is not considered the Statement of Health.**