CAMP TRIUMPH IMMUNIZATION FORM

Please fill out form as completely as possible

Immunization history of _____ _____

Name of camper — Date of Birth

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	**Year of Basic Immunization**	**Year of Last Booster**
Diphtheria	1	1
Pertussis (Whooping Cough)	2	2
Tetanus	3	
or		
Tetanus TD		
Diptheria		
or		
Tetanus		
Oral Polio (Sabin) TOPV Injectable		
Polio (Salk)		
Measles, Mumps, Rubella		
Hepatitis B		
Varicella & MenACWY		
COVID -19		
Tuberculin Test results (most recent)	Circle: - / +	Date

Licensed physician's signature_____ Phone_ (____)_____

Address_____

Date of Form Completion_____ *By_____

*Initial if completed by nurse or physician's assistant.

Instructions for Doctor:

Please complete the above including the physician's signature and send immediately to:

Triumph Center, Inc.
Main Office
36 Woburn Street
Reading, MA 01867
(781) 942-9277
FAX (781) 944-6535

Please return all forms and correspondence to our ***Main office at 36 Woburn Street. Reading, MA 01867***