Immunizations Record Form (for ages 5-11)

Camper's First & Last Name _____ **D.O.B** _____

The state of Massachusetts require campers aged 5 - 11 to have, and provide evidence of the following immunizations:

The deadline for submitting proof of immunizations is 10 days before the chosen session start date.

1. If the camper is returning to camp, please contact the office to see if the required information is currently held on our system from previous years.

2. A copy of your camper's vaccination record from their healthcare provider is acceptable. Alternatively, you may download a template of the Immunization Record Form from our website and request a licensed healthcare provider to complete it.

3. There are four options for submitting this information:

   - Upload a PDF document to your camper's CampInTouch account.
   - Fax to (978) 225-2745.
   - Email office@grotonwood.org.
   - Mail to 167 Prescott St, Groton MA 01450.

4. Upon receipt, our nurses will review the documents and follow up on any queries. If you have any questions do not hesitate to contact the office at (978) 448 5763 or email office@grotonwood.org.

To be completed by a Healthcare provider. All dates must include MONTH, DAY and YEAR.

MMR	**2 doses;** first dose must be given on or after the 1st birthday and the 2nd dose must be given ≥28 days after dose 1; laboratory evidence of immunity acceptable	
	Dose 1 (MM/DD/YY)	**Dose 2 (MM/DD/YY)**
Complete the following **ONLY** if individual vaccines were received for Measles, Mumps, and Rubella:		
Measles (Rubeola) Vaccine	**Dose 1 (MM/DD/YY)**	**Dose 2 (MM/DD/YY)**
Rubella (German Measles) Vaccine	**Dose 1 (MM/DD/YY)**	**Dose 2 (MM/DD/YY)**
Mumps Vaccine	**Dose 1 (MM/DD/YY)**	**Dose 2 (MM/DD/YY)**
If proof of vaccine cannot be provided, a camper must obtain a **blood titer** to confirm immunity of all of the above.		

Polio	**4 doses;** 4th dose must be given on or after the 4th birthday and ≥6 months after the previous dose, or a 5th dose is required. 3 doses are acceptable if the 3rd dose is given on or after the 4th birthday and ≥6 months after the previous dose.				
	Dose 1 (MM/DD/YY)	**Dose 2 (MM/DD/YY)**	**Dose 3 (MM/DD/YY)**	**Dose 4 (MM/DD/YY)**	**Dose 5 (MM/DD/YY)**
DTaP	**5 doses;** 4 doses are acceptable if the 4th dose is given on or after the 4th birthday. DT is only acceptable with a letter stating a medical contraindication to DTaP.				
	Dose 1 (MM/DD/YY)	**Dose 2 (MM/DD/YY)**	**Dose 3 (MM/DD/YY)**	**Dose 4 (MM/DD/YY)**	**Dose 5 (MM/DD/YY)**
Varicella (Chicken Pox)	**2 doses;** first dose must be given on or after the 1st birthday, and 2nd dose must be given ≥28 days after dose 1; a reliable history of chickenpox* or laboratory evidence of immunity is acceptable				
	Dose 1 (MM/DD/YY)		**Dose 2 (MM/DD/YY)**		

*A reliable history of chickenpox includes a diagnosis of chickenpox, or interpretation of parent/guardian description of chickenpox, by a physician, nurse practitioner, physician assistant, or designee.

Hepatitis B	**3 doses;** laboratory evidence of immunity acceptable		
	Dose 1 (MM/DD/YY)	**Dose 2 (MM/DD/YY)**	**Dose 3 (MM/DD/YY)**

Healthcare Provider Certification

Provider's Printed Name		**Phone**	
Provider's Signature		**Date**	
Health Center Address			

Thank you for completing this form.