Camper

Staff

YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS AND STAFF

Physical Exams Are Valid For 3 Years From Date of Last Examination

Please Return Completed Form to the Camp

Name_____ Date of Birth_____ Phone_____

Guardian_____ Address_____

Emergency Contact_____ Telephone_____

Date of Arrival at Camp_____ Departure Date _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

____ May participate in all camp activities

____ May participate except for: _____

_____

Medical information pertinent to routine care and emergencies_____

_____

Is this individual taking prescription or over the counter medication(s)? YES NO If yes, indicate names of medications(s)

_____

Does the individual have allergies? YES NO Explain:_____

Is the individual on a special diet? YES NO Explain:_____

Does the individual have special needs? YES NO Explain:_____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	**No**		**Yes**	**No**
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Comments:_____

_____

_____

Print name of medical care provider:_____

Medical care provider's address:_____

Medical care provider's" City/Town_____ State_____ Zip Code_____

_____

Signature of Physician, APRN or PA

_____

Date Form Signed

_____

Telephone Number