

YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS & STAFF

Physical exams are valid for 3 years from date of last examination

Camper ***Please return completed form to the camp***

Staff

Name _____ Date of birth _____ Sex _____ Phone _____

Guardian _____ Address _____

Emergency Contact Telephone _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

_____ May participate in all camp activities **Date of Exam** _____ / _____ / _____

_____ May participate except for: _____

Medical information pertinent to routine care & emergencies: _____

Is this individual taking prescriptions or over the counter medication(s)? YES NO If YES, indicate names of Medication(s) _____

Does the individual have allergies? NO YES, Explain: _____

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

Does the individual have special needs? NO YES, 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			Pneumococcal conjugate		
Tetanus			Polio		

Comments _____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's City/Town _____ ST. _____ Zip Code _____ Phone# _____

Signature of Physician, PA, APRN, or RN: _____ **Date form Signed** _____

Additional comments/information from parent/guardian: