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: