

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



Camper Name _____ Date of Birth _____ Phone _____

Guardian Address _____

Emergency Contact Telephone _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam ____/____/____

_____ 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 medication(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			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 _____

Signature of Physician, PA, APRN or RN

Date Form Signed

Telephone Number