

**YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF**
Physical Exams are Valid for 1 Year
From Date of Last Examination

Camper
 Staff

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:

Date of Exams ____/____/____

_____ 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 medicine(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 _____ State _____ Zip Code _____

Signature of Physician, PA, APRN or RN

Date Form Signed

Telephone Number