

**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

Staff/ Camper

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 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	Polio
		Tetanus	

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 _____