



YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS AND STAFF

Physical Exams Are Valid for 3 years
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 _____

A new health form must be submitted each year

**TO BE COMPLETED BY THE SPECIFIED
MEDICAL PRATITIONER:**

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		
Chicken Pox			Pneumococcal conjugate		
Tetanus			Polio		

Comments: _____

Print name of medical 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