BOYS & GIRLS CLUB
OF THE LOWER NAUGATUCK VALLEY

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 WITH immunization records attached

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: _____

Does the individual have any known medical or emotional illness or disorder that poses a risk to other children or which affects the individual's functional ability to participate safely in a youth camp? If yes, please explain: ❑ YES ❑ NO

_____

Are there any prescription or over-the-counter medication(s) this individual needs to take while at camp? ❑ YES ❑ NO

If yes, indicate name(s) of medication(s): _____

NOTE: A written authorization and parent permission for the administration of medicine at camp are required.

Does the individual have any disabilities or special health care needs such as allergies, special dietary needs? ❑ YES ❑ NO

If yes, please explain: _____

NOTE: If the camper has a special health care need or disability that requires special care be taken or provided during the time the individual is at camp, an individual plan of care shall be developed with the parent and health care provider and updated as necessary. The plan shall include appropriate care of the camper in the event of a medical or other emergency and signed by the parent and staff responsible for the care of the camper.

If camper/staff is school aged or younger, have they been immunized in accordance with the schedule adopted by the Commissioner of Public Health Pursuant to section 19a-7f of the Connecticut General Statutes? ❑ YES ❑ NO

Additional Comments: _____

_____

Printed Name of Health Care Provider: _____

Address: _____ Phone _____

Signature of Physician, PA, APRN or Rn _____ Date form Signed _____