

YOUTH CAMP HEALTH EXAM/RECORD For Campers and Staff

PLEASE RETURN COMPLETED FORM TO THE CAMP Camper Staff

NAME _____ DATE OF BIRTH _____ PHONE _____

GUARDIAN _____ ADDRESS _____

EMERGENCY CONTACT _____ PHONE _____

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			Pneumococcal conjugate		
Tetanus			Polio		

Comments: _____

PRINT NAME OF MEDICAL CARE PROVIDER: _____

MEDICAL CARE PROVIDER'S ADDRESS: _____

CITY/TOWN _____ STATE _____ ZIP CODE _____

Signature of Physician, PA, APRN or RN

Date Form Signed

Telephone Number