Youth Camp Health Exam/Record for Campers and Staff

Physical Exams are valid for 2 years From Date of Last Examination

☐ Camper ☐ Staff

Name:______________________ **Birthday:**____________ **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 the individual taking prescription medication? ☐YES ☐NO If yes, indicate prescription:____

Does the individual have allergies? ☐YES ☐NO

Explain:____

Is the individual on a special diet? ☐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**
Measles		
Mumps		
Rubella		
Chickenpox		
Tetanus		
Hepatitis B		
Diptheria		
Pertussis		
Polio		

Print name of medical care provider: ____________________________

Medical Care Provider's address: ______________________________

Medical Care Provider's: City/Town ________________ ST ____ Zip ______________

___________________________ ___________________________

(Signature of Physician, APRN or PA) (Date Form Signed)

____

(Telephone Number)