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

☐ **CAMPER** ☐ **STAFF**

Name: _____Date of Birth: _____Phone: _____
(dd/mm/yyyy)

Guardian: _____Address: _____

Emergency Contact:_____Emergency Phone: _____

Date of Arrival at Camp: _____Date of Departure: _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

☐ May participate in all camp activities

DATE of EXAM _____/_____/_____

☐ May participate except for: _____

_____

Medical information pertinent to routine care and emergencies: _____

Does the individual have allergies? ☐ YES ○ NO Explain:
_____

Is the individual on a specific 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 the 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: _____ City_____ St_____ Zip Code _____

_____ _____ _____

Signature of Physician, PA, APRN or RN **Date Form Signed** **Telephone Number**