

# 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		
Diphtheria		
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)