YOUTH CAMP HEALTH EXAM/RECORD

FOR CAMPERS AND STAFF
From Date of Last Examination

☐Camper ***Please Return Completed Form to the Camp***
☐Staff

Name _____Date of Birth _____Phone_____
Guardian _____Address _____
Emergency Contact _____Telephone _____
Date of Arrival at Camp: _____ Departure Date:_____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam (Within the last year)____/____/____
_____ May participate in all camp activities
_____ May participate except for: _____
_____
Medical information pertinent to routine care and emeergencies:_____
_____

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			Polio		
Tetanus					

Comments_____
_____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town_____ ST_____ Zip Code_____

_____
Signature of Physician, APRN or PA

_____
Date Form Signed

_____
Telephone Number

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