St. Patrick's G.A.A. of Connecticut

YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF

Physical Exams Are Valid For 3 Years
From Date of Last Examination

☐Camper ☐Staff

First Name_____ Middle Name_____ Last Name_____

Date of Birth (mm/dd/yyyy)_____

Guardian Name_____ Tel No._____

Guardian Address_____

Emergency Contact Name:_____

Emergency Contact Tel No:_____

Date of Arrival at Camp: Monday June 27, 2016 Departure Date: Friday July 1, 2016

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam (mm/dd/yyyy) ____/____/____

_____ May participate in all camp activities
_____ May participate except for:

_____

_____

_____

Medical Care Pertinent to Routine Care or Emergencies: _____

_____

_____

Is the Individual taking prescription or over the counter medication(s) ☐Yes ☐No If yes, indicate name 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			Diptheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Comments:_____

_____

_____

Print name of medical care provider: _____
Medical Care Provider's Address:_____
Medical Care Provider's City/Town_____ State_____ Zip Code_____

_____
Signature of Physician, P.A. APRN or RN

Date Form Signed(mm/dd/yyyy) ____/____/____ Telephone Number:_____