

**YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF**

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

Camper

Please Return Completed Form to 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 _____

_____ May participate in all camp activities

_____ May participate except for: _____

Medical information pertinent to routine care and emergencies:

Is this 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		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