**2020**

**YOUTH CAMP HEALTH EXAM/RECORD**

**FOR CAMPERS AND STAFF**

**Physical Exams Are Valid For 3 years**

**From Date of Last Examination**

|  |  |
| --- | --- |
|  Camper Staff |  ***Please Return Completed Form to the Camp*** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  | Date of Birth |  | Phone |  |
| Guardian |  | Address |  |
| Emergency Contact |  | Telephone |  |
| Date of Arrival at Camp |  | Departure Date |  |
|  |

|  |
| --- |
| **A new health form must be submitted every year.** |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TO BE COMPLETED BY THE SPECIFIED MEDICAL PRATITIONER:** |  |  |  |  |  |  |  |  |
|  | **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 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 |  |  |
| Chicken Pox |  |  | Polio |  |  |
| Tetanus |  |  |  |  |  |
|  |  |  |  |  |  |
| Comments: |  |
|  |
|  |
|  |
| Print name of medical provider: |  |
| Medical care provider’s address: |  |
| Medical care provider’s: City/Town |  | ST |  | Zip Code |  |
|  |  |
|  | Signature of Physician, PA, APRN or RN |
|  |  |
|  | Date Form Signed |