**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 | |  | | | |
|  | | | | | | | | | | | | |

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

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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 | | | | | | | | | | | | |