YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF

☐ Camper
☐ 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

_____

TelephoneNumber