

## Youth Camp Health Exam/Record for Campers and Staff

Camper  Staff

**Name:** \_\_\_\_\_ **Birthday:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Guardian:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**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 the 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
Measles		
Mumps		
Rubella		
Chickenpox		
Tetanus		
Hepatitis B		
Diphtheria		
Pertussis		
Polio		

Print name of medical care provider: \_\_\_\_\_

Medical Care Provider's address: \_\_\_\_\_

Medical Care Provider's: City/Town \_\_\_\_\_ ST \_\_\_\_ Zip \_\_\_\_\_

\_\_\_\_\_  
(Signature of Physician, APRN or PA)

\_\_\_\_\_  
(Date Form Signed)

\_\_\_\_\_  
(Telephone Number)