

# Youth Camp Health Exam/Record for Campers and Staff

Physical exams are valid for 3 years from date of last examination!  
Please return completed form to Camp.

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 \_\_\_\_\_

Check One:

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, explain:

\_\_\_\_\_

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 of 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    | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B | <input type="checkbox"/> | <input type="checkbox"/> |
| Mumps      | <input type="checkbox"/> | <input type="checkbox"/> | Diphtheria  | <input type="checkbox"/> | <input type="checkbox"/> |
| Rubella    | <input type="checkbox"/> | <input type="checkbox"/> | Pertussis   | <input type="checkbox"/> | <input type="checkbox"/> |
| Chickenpox | <input type="checkbox"/> | <input type="checkbox"/> | Polio       | <input type="checkbox"/> | <input type="checkbox"/> |
| Tetanus    | <input type="checkbox"/> | <input type="checkbox"/> |             |                          |                          |

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 \_\_\_\_\_