

**YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF**
Physical Exams are Valid for 3 Years
From Date of Last Examination

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

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
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 Code _____

Signature of Physician, APRN or PA

Date Form Signed

Telephone Number