

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 _____
 Emergency
 Contact _____ Telephone _____

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 _____

_____ Phone _____

Signature of Physician, APRN or PA

Date Form Signed