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

☐Camper Please Return Completed Form to Camp
❑Staff

Name _____ Date of Birth _____ Phone_____
Guardian_____ Address_____
Emergency Contact _____ Telephone_____
Date of Arrival at Camp: _____ Departure Date:_____ ----------
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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 _____
Telephone Number_____