Youth Camp Health Exam/Record for Campers and Staff

Physical Exams are valid for 2 years From Date of Last Examination

☐ 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		
Diptheria		
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)