

YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS

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 _____

_____ 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(s): _____

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: _____

Name of medical care provider (printed) _____

Street address _____

City _____ State _____ Zip Code _____

Signature of Physician, APRN or PA

Date Form Signed

Telephone Number