SAMPLE FORM

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

☐ Camper
☐ Staff

Please Return Completed Form to the Camp

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 or over the counter medication(s)? ☐ YES ☐ NO If yes, indicate names of medication(s): ____________________________

Does the individual have allergies? ☐ YES ☐ NO Explain: ____________________________

Is the individual on a special diet? ☐ YES ☐ NO Explain: ____________________________

Does the individual have special needs? ☐ 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:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td>Hepatitis B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td>Diphtheria</td>
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<tr>
<td>Rubella</td>
<td></td>
<td>Pertussis</td>
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</tr>
<tr>
<td>Chickenpox</td>
<td></td>
<td>Pneumococcal conjugate</td>
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<tr>
<td>Tetanus</td>
<td></td>
<td>Polio</td>
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</tbody>
</table>

Comments: ____________________________

__________________________________________

Print name of medical care provider:

Medical care provider’s address:

Medical care provider’s: City/Town________________ ST Zip Code__________

__________________________________________

Signature of Physician, PA, APRN or RN

Date Form Signed

__________________________________________

Telephone Number