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:

_____

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:

	Yes (mm/dd/yy)	No		Yes (mm/dd/yy)	No
Measles	/ / /		Hepatitis B	/ / /	
Mumps	/ / /		Diphtheria	/ / /	
Rubella	/ / /		Pertussis	/ / /	
Chickenpox	/ / /		Pneumococcal conjugate	/ / /	
Tetanus	/ / /		Polio	/ / /	

Comments: _____

_____

_____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town _____State _____Zip Code_____

_____
Signature of Physician, PA, APRN or RN

_____
Date Form Signed

_____
Telephone Number

Parent or Guardian authorization **(Required for all under 19)**

This health history is correct so far as I know, and the person named above has permission to participate in all camp activities except as noted by me or the examining physician. If I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to Hospitalize, secure proper treatment for, and order injections, anesthesia for surgery for the person named above.

Signature _____ Date _____

Insurance Information

Hospital Insurance.....

Major Medical (if different) .....

Name of Insured Person on Plan .....

Policy Number .....

Insurance Company Address .....