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 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 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

Medications and Additional Camper Information

MEDICATIONS BEING TAKEN

Please list ALL medications / including over-the-counter or nonprescription drugs/ taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician/ if a prescription drug/, the name of the medication, the dosage, and the frequency of administration.

Child's Name:_____

- ❑ This person takes NO medication on a routine basis.
- ❑ This person takes medications as follows:

Med #1_____Dosage_____Specific times taken each day_____

Reason for taking_____

Med # 2 _____Dosage_____Specific times taken each day_____

Reason for taking_____

Med #3_____Dosage_____ Specific times taken each day_____

Reason for taking_____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer:

_____

_____

_____

DIETARY RESTRICTIONS
The following restrictions apply to this individual.

- ❑ Does not eat eggs
- ❑ Does not eat poultry
- ❑ Does not eat seafood
- ❑ Does not eat dairy products
- ❑ Other / describe/

Explain any restrictions to activity or behavioral issues: (e.g. what cannot be done, what adaptations or limitations are necessary?)_____