

**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:

|            | <b>Yes</b> | <b>No</b> |                        | <b>Yes</b> | <b>No</b> |
|------------|------------|-----------|------------------------|------------|-----------|
| 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 \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician, PA, APRN or RN

\_\_\_\_\_  
Date Form Signed

\_\_\_\_\_  
Telephone Number