2020

YOUTH CAMP HEALTH EXAM/RECORD

Physical Exams Are Valid for 3 Year
From Date of Last Examination

Please Return Completed Form to the Camp

Name _____ D.O.B._____ HT _____ WT _____
Guardian _____ Phones _____
Cell *Home*
Address _____ Email _____
Street *Town* *Zip*

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam ____/____/_____

_____ May participate in all 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 Medications(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 individual 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			Pneumococcal Conjugate		
Tetanus			Polio		

Comments:_____
_____
_____
Print name of medical care provider:_____
Medical care provider's address:_____
Street *Town* *State* *Zip*

_____
Signature of Physician, PA, APRN or RN

_____
Date form Signed

_____
Telephone Number

A new Health Exam Record must be supplied each year.