

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

Please Return Completed Form To Parks & Recreation Office

- Camper
- Staff

Name _____ Date of Birth _____ Phone _____
Guardian _____ Address _____
Emergency Contact _____ Phone _____
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 AP

Date Form Signed

Telephone Number

