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

___Camper **Please Return Completed Form to the Camp**
___Staff
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:
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 _____