

**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:**

<b>Date of Exam</b> _____
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\_\_\_\_\_ 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:

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
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