

**Medical Form I**

**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 the Camp**

- Camper
- 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:**

\_\_\_\_\_ May participate in all camp activities

\_\_\_\_\_ May participate except for:

**Date of Exam** \_\_\_\_/\_\_\_\_/\_\_\_\_

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		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, PA, APRN or RN: \_\_\_\_\_

Date Signed: \_\_\_\_\_ Telephone Number: \_\_\_\_\_