SUMMER CAMPS 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_____

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 medications(s): _____

Does the individual have allergies? ☐ NO ☐ YES Explain: _____

Is the individual on a special diet? ☐YES ☐ NO Explain: _____

Does the individual have special needs? ☐ YES ☐ NO Explain: _____

*Development Assessments: (Birth – 5 years) ☐ YES ☐ NO Type: _____

Results: _____

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:

Measles	Yes	No
Hepatitis B	Yes	No
Mumps	Yes	No
Diphtheria	Yes	No
Rubella	Yes	No
Pertussis	Yes	No
Chickenpox	Yes	No
Pneumococcal conjugate	Yes	No
Tetanus	Yes	No
Polio	Yes	No

Comments: _____

_____

_____

Medical Care Provider:

Print name of medical care provider:

_____

Medical care provider's address:

_____

City/Town_____ST____Zip Code_____

Medical care provider's phone _____

_____

Signature of Physician, PA, APRN or RNR Date Form Signed