YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS

PLEASE RETURN COMPLETED FORM PRIOR TO CAMP

CHILD'S NAME: _____ D.O.B.: _____ PHONE: _____

GUARDIAN: _____ ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE (H): _____

DATE OF CAMP ARRIVAL: _____ PHONE (W): _____

DATE OF CAMP DEPARTURE: _____ PHONE (CELL): _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

DATE OF EXAM: _____

MAY PARTICIPATE IN ALL CAMP ACTIVITIES: YES _____ NO _____

MAY PARTICIPATE IN ALL CAMP ACTIVITIES EXCEPT FOR: _____

_____

MEDICAL INFORMATION PERTINENT TO ROUTINE CARE AND EMERGENCIES: _____

_____

IS THE INDIVIDUAL TAKING PRESCRIPTION MEDICATION? YES _____ NO _____

IF YES, PLEASE INDICATE PRESCRIPTION: _____

DOES THE INDIVIDUAL HAVE ALLERGIES? YES __ NO __ EXPLAIN: _____

IS THE INDIVIDUAL ON A SPECIAL DIET? YES __ NO __ EXPLAIN: _____

THIS CAMPER IS UP-TO-DATE ON ALL THE FOLLOWING ROUTINE CHILHOOD IMMUNIZATIONS CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICIANS AND NATIONAL ADVISORY COMMITTEE ON IMMUNIZATIONS PRACTICES:

	YES	NO		YES	NO
MEASLES			HEPATITIS		
MUMPS			DIPHTHERIA		
RUBELLA			PERTUSSIS		
CHICKENPOX			POLIO		
TETANUS					

COMMENTS _____

_____

PRINT NAME OF MEDICAL CARE PROVIDER: _____

MEDICAL CARE ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

SIGNATURE OF PHYSICIAN, APRN, OR PA: _____ DATE FORM SIGNED: _____

TELEPHONE NUMBER: _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION (Self-Administration may be authorized by parent and prescriber)

PRESCRIBER'S AUTHORIZATION FOR SELF-ADMINISTRATION __ YES __ NO _____

PARENT/GUARDIAN'S AUTHORIZATION FOR SELF-ADMINISTRATION __ YES __ NO _____