



HEALTH EXAM/RECORD

PHYSICAL EXAMS ARE VALID FOR 3 YEARS FROM DATE OF LAST EXAMINATION

Camper
Staff

Please mail/fax the completed form prior to the start date of camp

Name: _____ Date of Birth: ___/___/___ Phone: (____)_____

Guardian: _____ Address: _____

Emergency Contact: _____ Telephone: (____)_____

Camp Location: _____ 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 medications? YES NO

(If yes, please indicate names of medications) _____

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	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis	<input type="checkbox"/>	<input type="checkbox"/>
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal conjugate	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Print name of medical care provider: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Signature of Physician, PA, APRN or RN

Date: _____ Telephone: (____)_____