

## YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS

**Denison Pequotsepos Nature Center, P.O. Box 122, Mystic, CT, 860-536-1216**

**Physical Exams Are Valid For 3 Years  
From Date of Last Examination**

*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:

**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 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 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, APRN or PA**

\_\_\_\_\_  
**Date Form Signed**

\_\_\_\_\_  
**Telephone Number**