Summer Camp Group ____________ Session Number ____________

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