YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF
Physical Exams Are Valid For 3 Years
From Date of Last Examination

☐ Camper
☐ Staff

Please Return Completed Form to the Camp

Name______________________________ Date of Birth __________ Phone________________

Guardian ____________________ Address ______________________________________

Emergency Contact ______________________________________ Telephone______________

Date of Arrival at Camp: ______________________ Departure Date: ______________________

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Date of Exam ____/____/____

May participate in all camp activities ☐ YES ☐ NO

May participate except for: ____

Does the individual have any known medical or emotional illness or disorder that poses a risk to other children or which affects the individual's functional ability to participate safely in a youth camp? ☐ YES ☐ NO

If yes, please explain ____

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Are there any prescription or over the counter medication(s) this individual needs to take while at camp? ☐ YES ☐ NO

If yes, indicate names of medication(s):_______________________________________

NOTE: A written authorization and parent permission for the administration of medication at camp are required.

Does the individual have any disabilities or special health care needs such as allergies, special dietary needs? ☐ YES ☐ NO

If yes, please explain ____

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NOTE: If the camper has a special health care need or disability that requires special care be taken or provided during the time the individual is at camp, an individual plan of care shall be developed with the parent and health care provider and updated as necessary. The plan shall include appropriate care of the camper in the event of a medical or other emergency and signed by the parent and staff responsible for the care of the camper.

If camper/staff is school aged or younger, have they been immunized in accordance with the schedule adopted by the Commissioner of Public Health pursuant to section 19a-7f of the Connecticut General Statutes? ☐ YES ☐ NO

***** Copy of immunization is REQUIRED*****

Additional Comments:

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Printed Name of Health Care Provider: ____

Address: ______________________________________ Phone: __________________

Signature of Physician, PA, APRN or RN ________________________ Date Form Signed: ____________