New England Pediatrics

YOUTH CAMP HEALTH EXAM/RECORD
For Campers and Staff

PLEASE RETURN COMPLETED FORM TO THE CAMP ☐ Camper ☐ Staff

NAME _____ DATE OF BIRTH _____ PHONE _____

GUARDIAN _____ ADDRESS _____

EMERGENCY CONTACT _____ PHONE _____

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 medication(s)? ☐ YES ☐ NO
If yes, indicate names of medication(s): _____
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	☐	☐	Hepatitis B	☐	☐
Mumps	☐	☐	Diphtheria	☐	☐
Rubella	☐	☐	Pertussis	☐	☐
Chickenpox	☐	☐	Pneumococcal conjugate	☐	☐
Tetanus	☐	☐	Polio	☐	☐

Comments: _____

PRINT NAME OF MEDICAL CARE PROVIDER: _____

MEDICAL CARE PROVIDER'S ADDRESS: _____

CITY/TOWN _____ STATE _____ ZIP CODE _____

_____
Signature of Physician, PA, APRN or RN Date Form Signed Telephone Number

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