



YOUTH CAMP HEALTH FORM FOR CAMPERS AND STAFF

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

- Camper
 Staff

This form MUST be filled out by your doctor in order for your child to attend Mountain Mist Day Camp.

TO BE COMPLETED BY PARENT:

Name: _____ Date of Birth: _____ Phone: _____

Guardian: _____ Address: _____

Emergency Contact # 1: _____ Relationship: _____ Telephone: _____

Emergency Contact # 2: _____ Relationship: _____ Telephone: _____

CODE WORD: _____

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: _____

Medical care provider's City/Town: _____ ST: _____ Zip Code: _____

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

Telephone Number _____