



**YOUTH CAMP HEALTH EXAM/RECORD  
FOR CAMPER 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 \_\_\_\_\_  
\_\_\_\_\_

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 \_\_\_\_\_  
\_\_\_\_\_

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

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_

Printed Name of Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician, PA, APRN or RN \_\_\_\_\_ Date Form Signed: \_\_\_\_\_