

# YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS AND STAFF

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

**Please Return Completed Form to the Camp**

Camper

Staff

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Guardian \_\_\_\_\_ Address \_\_\_\_\_

Emergency Contact Telephone \_\_\_\_\_

## TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

\_\_\_\_\_ May participate in all camp activities

**Date of Exam** \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ 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 \_\_\_\_\_ Telephone Number: \_\_\_\_\_

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

## Permission Form

Completed health & permission forms must be received prior to the start of camp.

**Camper's Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

### Parent or Legal Guardian Authorization:

The camper named above has permission to participate in all camp activities except as noted by the examining physician on the child's provided current physical form. I understand that such activity may involve strenuous physical activity and/or hazardous conditions. I further grant permission to Environmental Learning Centers of Connecticut (ELCCT) and its agents and employees to seek and obtain medical, dental, or hospital care for my child in my place if deemed necessary by said agents and employees. I also grant permission to Environmental Learning Centers of Connecticut and its agents and employees to administer first aid using the medication listed on the provided physical examination form as needed unless otherwise noted by the child's physician. I further understand that transportation may be provided by private or public motor vehicles furnished by ELCCT personnel, volunteers or third parties.

**Signature of Parent or Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_