FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

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 on or prior to your camper/s attending camp

☐ Camper
☐ Staff

Name _____ Date of Birth _____ Phone _____

Guardian Address _____

Emergency Contact _____ Telephone _____

Date of Arrival at Camp: _____ Departure Date: _____

Parent or Guardian Authorization (required for all persons under age of 18) This health history is correct so far as I know, and the person named above has permission to participate in all camp activities except as noted by me or the examining physician. If I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia for surgery for the person name above.

Parent or Guardian Signature X _____ 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: _____

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

Signature of Physician, PA, APRN or RN: **X** _____

Date Form Signed _____ Telephone Number _____

Mail or Bring to: Middlesex YMCA, Attention: R. Johnson, 99 Union Street, Middletown, CT 06457.
Email: rjohnson@midymca.org. Fax: 860-342-2267

YMCA Camp Ingersoll
94 Camp Ingersoll Rd. Portland, CT 06480
P 860•342•2267 F 860•343•6254 www.campingersoll.org

Last Name:

First Name: