



# Summer Camps

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Date of Exam: \_\_\_\_\_

## YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS AND STAFF

Name: \_\_\_\_\_ Phone # \_\_\_\_\_ D.O.B. \_\_\_\_\_

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

Identify any known medical or emotional illness or disorder that would currently pose a risk to others or which would currently affect the individual's functional ability to participate safely:

\_\_\_\_\_

\_\_\_\_\_

Medical information pertinent to routine care and emergencies:

\_\_\_\_\_

\_\_\_\_\_

Is this individual taking prescription medication?  YES  NO

If yes, indicate prescription: \_\_\_\_\_

Does the individual have allergies?  YES  NO

Explain: \_\_\_\_\_

Is the individual on a special diet?  YES  NO

Explain: \_\_\_\_\_

### IMMUNIZATION RECORD: (Month, Day, Year for each dose)

IMMUNIZATION	DATE					IMMUNIZATION	DATE
	1st DOSE	2nd DOSE	3rd DOSE	4th DOSE	5th DOSE		
DTP/DTaP/DT						MMR ( 1st Dose)	
OPV/IPV						MEASLES (2nd Dose)	
Hib (HAEMOPHILUS INFLUENZA TYPE B)						VARICELLA (Chicken Pox) (Reccommended)	
HEPATITAS B						OTHER (Specify)	

Are there medical contraindications to immunization?  Yes  No

If yes, specify the vaccine(s) and indicate the contraindicafions specified in the vaccine manufacturers' package insert that applies.

\_\_\_\_\_

Does this individual have laboratory confirmed proof of immunity to natural infection?  Yes  No

If yes, please explain and attach laboratory report: \_\_\_\_\_

Is this individual current or in progress with immunizations according to the schedule adopted by the Commissioner of Public Health?  Yes  No Next Appointment for Immunization is scheduled \_\_\_\_\_

Month/Day/Year

Medical Care Provider (Name, Address, Telephone#): Signature of MD, APRN or PA: \_\_\_\_\_

Date Form Signed: \_\_\_\_\_