YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF
Physical exams are valid for 3 years from date of last examination

☐ Camper ***Return Completed Form to ASAP! by July 1, 2019***

☐ Staff We prefer forms be **mailed** to: ASAP!, P.O. Box 15, Washington Depot, CT 06794

Forms may also be faxed to: Washington Montessori, Attention ASAP! SUMMER CAMP, 860-868-1362

Name_____ Date of Birth_____ Phone_____

Guardian(s)_____ Address_____

Emergency Contact_____ Phone_____

Date of Arrival at Camp_____ Departure 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, indication 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: _____

REQUIRED: IMMUNIZATION HISTORY MUST BE ATTACHED

Comments: _____

_____

_____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's City/Town: _____ State_____ Zip Code_____

_____

Signature of Physician, PA, APRN or RN

_____

Date Form Signed

_____

Telephone Number