

YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS & STAFF

*Physical exams are valid for 3 years from date of last examination

Return completed form by June 28, 2021 to asap@asapct.org

or mail to: ASAP! PO Box 15, Washington Depot, CT 06794

CAMPER

STAFF

Name _____ Date of Birth _____ Phone _____

Guardian(s) _____ Address _____

Emergency Contact Name(s) _____ Emergency Contact Phone _____

Date of Arrival at Camp _____ Departure Date _____

TO BE COMPLETED BY SPECIFIED 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: _____

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