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 30, 2025 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