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 to:
asap@asapct.org ***-or-*** 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_____
Camp Arrival Date_____ 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