

# BLUE CHIP 225 CAMP HEALTH EXAM/RECORD for Campers & Staff

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

Rising Senior (grad 2010) Camper \_\_\_\_\_ Rising Junior (grad 2011) Camper \_\_\_\_\_ STAFF \_\_\_\_\_

Camper/Staff Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_

Date of Arrival at camp \_\_\_\_\_ Date of Departure from camp \_\_\_\_\_

## TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

Date of exam \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Individual CAN participate in all camp activities:    YES    NO    If No please indicate exclusions \_\_\_\_\_

Medical care pertinent to routine care and emergencies: \_\_\_\_\_

\_\_\_\_\_

Is the individual taking prescription or over the counter medication(s)? If yes indicate names of medication(s): \_\_\_\_\_

\_\_\_\_\_

Will this medication be BROUGHT TO and TAKEN at camp?    YES    NO

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: \_\_\_\_\_

This camper/staff is up to date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics:

	YES .....	NO .....		YES .....	NO .....		YES .....	NO .....
Measles			Hepatitis B			Polio		
Mumps			Diphtheria			Chickenpox		
Rubella			Pertussis			Tetanus-provide date of last shot		

Print Name of Medical Care Provider \_\_\_\_\_ Phone# \_\_\_\_\_

Medical Care Provider's address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SIGNATURE OF PHYSICIAN, PA, APRN or RN \_\_\_\_\_ Date \_\_\_\_\_