

PLEASE RETURN BY FAX 877-282-9440 OR SCAN TO EMAIL!! DO NOT MAIL!!

BLUE CHIP 225 CAMP HEALTH EXAM/RECORD

Rising Senior (grad 2013) _____ Rising Junior (grad 2014) _____ Rising Sophomore (grad 2015) _____

Camper 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 is up to date on all routine childhood immunizations currently recommended by the American Academy of Pediatrics:

DATE OF LAST TETANUS SHOT: _____

Print Name of Medical Care Provider _____ Phone# _____

Medical Care Provider's address _____ City _____ State _____ Zip _____

SIGNATURE OF PHYSICIAN, PA, APRN or RN _____ **Date** _____