YMCA Camp Thundermoon

NEW BRITAIN-BERLIN YMCA

YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS AND STAFF

Physical exams are valid for three (3) years from date of last examination.

Please return completed form to the New Britain-Berlin YMCA at least one week prior to the child's first day of camp.

Last Name: _____

First Name: _____

❑ Camper ❑ Staff

Name: _____ Date of Birth: _____ Phone: _____

Parent or Guardian: _____

Address: _____

Emergency Contact: _____ Phone: _____

Date of Arrival at Camp: _____ Departure Date: _____

Parent or Guardian Authorization (required for all persons under the age of 18). This health history is correct so far as I know, and the person named above has permission to participate in all camp activities except as noted by me or the examining physician. If I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia for surgery for the person namec above.

Parent or Guardian Signature: **X** _____ Date: _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL 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: _____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			**Hepatitis B**		
Mumps			**Diphtheria**		
Rubella			**Pertussis**		
Chickenpox			**Pneumococcal conjugate**		
Tetanus			**Polio**		

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: **X** _____

Date Form Signed: _____ Phone: _____

Mail or bring to: **New Britain-Berlin YMCA 50 High Street, New Britain, CT 06051.**
Attention: YMCA Camp Thundermoon - First Aid Director.