



**FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY**

**YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPER AND STAFF**

Physical Exams Are Valid For 3 Years From Date of Last Examination

Please Return Completed Form to the Camp on or prior to your camper/s attending camp

- Camper
 Staff

Name _____ Date of Birth _____ Phone _____
Guardian Address _____
Emergency Contact _____ Telephone _____
Date of Arrival at Camp: _____ Departure Date: _____

Parent or Guardian Authorization (required for all persons under 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 name 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 _____ ST _____ Zip Code _____

Signature of Physician, PA, APRN or RN: **X** _____

Date Form Signed _____ Telephone Number _____

**Mail or Bring to: Middlesex YMCA, Attention: Rools Elysee. 99 Union Street, Middletown, CT 06457.
Email: relysee@midymca.org. Fax: 860-343-6254**

YMCA Camp Ingersoll
94 Camp Ingersoll Rd. Portland, CT 06480
P 860•342•2267 F 860•343•6254 www.campingersoll.org



Last Name:

First Name: