CAMP HAZEN YMCA

Physical Exam Form

Please return to camp by May 1.

Participant Name ______________________________ **D.O.B** ____________________

RECORD OF IMMUNIZATIONS

Vaccines	Month/Year Original Immunization	Month/Year Most Recent Booster
Tetanus	____________	____________
Diphtheria	____________	____________
Pertussis	____________	____________
Mumps	____________	____________
Measles	____________	____________
Rubella	____________	____________
Polio	____________	____________
Chicken Pox	____________	____________
Hepatitis B	____________	____________
HIB-haemophillus influenza b	____________	____________
PCP-Pneumococcal conjugate	____________	____________

Tuberculosis test given: Type__________ Date____________ Result_________

THIS SECTION TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER

Exam must be within 24 months prior to last day of camp

I examined the above named camp applicant on this date _____/_____/_____
MM / DD / YY

- ❑ In my opinion the condition of the camp applicant ALLOWS for the participation in an active camp program.
- ❑ In my opinion the condition of the camp applicant DOES NOT ALLOW for the participation in an active camp program.

The applicant is under the care of a physician for the following condition(s):

- ❑ Asthma
- ❑ Freq. Ear Infections
- ❑ Seizure Disorder
- ❑ GI Disorders
- ❑ Diabetes
- ❑ Heart Problem(s)
- ❑ ADD/ADHD
- ❑ Other____________
- ❑ Muscular/skeletal Injury
- ❑ Psychiatric diagnosis (i.e. depression, OCD, anxiety)

Current Treatment (include current medication): ____

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HEALTH CARE PROVIDER:

Provider Signature______________________________ **Date Form Signed**______________

Printed Name______________________________ **Phone**____________________

Address____