

Camper  
**Approved by CT-  
American Academy  
of Pediatrics**

**YOUTH CAMP HEALTH EXAM/RECORD  
FOR CAMPERS AND STAFF**  
State of Connecticut  
Physical Exams Are Valid For 3 Years Department of Public Health  
From Date of Last Examination  
Approved by CT-American Academy of Pediatrics

State of Connecticut  
Department of Public Health  
Division Community Based Regulation  
1-800-282-6063; (860) 509-8045

Staff

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_  
Guardian \_\_\_\_\_ Address \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_  
Date of Arrival at Camp: \_\_\_\_\_ Departure 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 medication?  YES  NO  
If yes, indicate prescription: \_\_\_\_\_

Does the individual have allergies?  YES  NO Explain: \_\_\_\_\_

Is the individual on a special diet?  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			Polio		
Tetanus					

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Print name of medical care provider: \_\_\_\_\_

Medical care provider's address: \_\_\_\_\_

Medical care provider's: City/Town \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician, APRN or PA

\_\_\_\_\_  
Date Form Signed

\_\_\_\_\_  
Telephone Number

# HEALTH FORM FOR ALL STUDENTS PARTICIPATING IN YPI

It is required that *both* sides of this form be completed and returned before YPI begins. No camper may attend YPI without both forms being completed and signed with by parent/guardian and physician.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## PERMISSION FOR MEDICAL CARE

I hereby grant permission to the Director of YPI, or his designee, to secure appropriate routine or emergency medical treatment for my child while attending YPI.

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PERSON TO BE NOTIFIED IN CASE OF AN EMERGENCY

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Phone (work): \_\_\_\_\_ Mobile: \_\_\_\_\_

## INSURANCE INFORMATION

Policy Holder's Name: \_\_\_\_\_

Insurance vendor: \_\_\_\_\_

Policy Number: \_\_\_\_\_

## PERMISSION TO ATTEND CAMP TRIPS AND ACTIVITIES

I hereby grant permission for my son/daughter to attend camp trips outside Suffield Academy with camp staff. YPI will provide buses or authorized vehicles.

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OVER**