PHYSICAL EXAM FORM YMCA CAMP BELKNAP

NOTE TO PARENT/GUARDIAN: Complete name and birthdate and provide form to your child's health care provider for completion.

CAMPER NAME: _____

Last **First** **Middle Initial**

BIRTH DATE:_____/_____/_____

NOTE TO HEALTH CARE PROVIDER: Please complete and sign this form and return to guardian to provide to camp. Please include updated immunization record. The named person will be attending YMCA Camp Belknap this summer. This camp is a traditional all boys residential camp with 1, 2, 4, 6, and 8 week sessions. If you have any questions about the program please call (603) 569-3475.

TODAY'S DATE:___/____/____

PHYSICAL EXAM COMPLETED ON: __/___/____ (must be within last 12 months)

VITAL SIGNS: Height:_____ Weight:_____ Blood Pressure:_____ Other:_____

ALLERGIES: (*Check and Describe*) ☐No Known ☐Food ☐Medicine ☐ Environment ☐other

Previous anaphylactic response? ☐ No ☐Yes *Please complete the separate Permission Form if needs to carry Epi-pen.*

DIET/NUTRITION: (mark response and describe below) ☐REGULAR or ☐ SPECIAL DIET

HEALTH HISTORY:

This camper/staff person is under the care of a physician for the **following conditions** (please describe):

Please list any other significant or pertinent past **illnesses, injuries or operations**:

Please describe any **developmental/social/emotional** history that may be helpful to know at camp:

MEDICATION: List the medications that the camper will be taking while at camp.

	Medication Name	Dose	Frequency	Route	Reason
1.					
2.					
3.					

Please provide separate sheet of paper if more medication is required. Routine medication times at camp are prior to meals and bedtime (7:45am, 12:45pm, 5:30pm, and 8:45pm). Complete separate Permission Form if medication needs to be on the camper while at camp.

List any other treatments or therapies to be continued at camp:

IMMUNIZATIONS: Attach Complete and Updated Immunization Record

RESTRICTIONS: Do you feel that this camper will require limitations or restrictions while at camp? ☐No☐Yes (If yes, please describe).

The above named person has been determined to be physically and emotionally fit to participate in camp and camp activities without restrictions except as noted above.

Licensed Provider Signature _____Date_____

Licensed Provider Name (printed):_____ Title:_____

Office Address:_____

Telephone:_(____)_____

CAMPER NAME Last: _____ First: _____ MI: _____

Rev 11/15/2016