HEALTH/PHYSICAL FORM

(Must be completed by Health Care Provider)

YMCA Camp Belknap
P: 603-569-3475
F: 603-569-1471
admincb@campbelknap.org

PARTICIPANT NAME:_____

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

BIRTHDATE:_____/_____/_____

NOTE TO HEALTH CARE PROVIDER: 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 or visit www.campbelknap.org.

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 To Possess and Use Form if needs to carry Epi-pen.***

MEDICATIONS: List the medications (including over-the-counter) that the camper will be taking while at camp.

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

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

IMMUNIZATIONS: ☐ **Attach Complete and Updated Immunization Record.** Date of Last Tetanus _____

DIET/NUTRITION: ☐ Regular or ☐ Special Diet (if special diet, please describe)

HEALTH HISTORY:

1. List Past or Current Health History (List any significant past or recent illness, injuries/fractures, concussions, seizures, headaches, bowel or bladder issues):

2. List Chronic Medical Conditions:

3. Does the participant have any Developmental/Social/Emotional history (examples: anxiety, depression, suicidal ideation, ADHD, bedwetting, IEP or 504)?: ☐ No ☐ Yes (If yes, please describe).

4. Does the participant have a Vision or Hearing Impairment? ☐ No ☐ Yes (If yes, please describe).

5. List Surgical History:

6. List Hospitalizations:

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: (____)_____

RETURN FORM TO GUARDIAN TO UPLOAD TO CAMPER'S ONLINE CAMP MEDICAL RECORD.