

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 overnight camp with 1, 2, 4, 6, and 8-week sessions. Belknap has choice programming. Campers choose to go to the program he likes, and he does NOT travel with his cabin. The camper must be able to safely get from one place in camp to another without being with or requiring another camper/staff. Campers maneuver rugged and varied terrain as part of daily camp life and program activities. 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 8:45pm). 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 Immunization Record including COVID vaccination.**

Date of Last Tetanus _____

DIET/NUTRITION: ☐ Regular or ☐ Diet requiring updates to menu (if diet/changes needed, please describe)

HEALTH HISTORY:

- List Past or Current Health History (List any significant past or recent illness, injuries/fractures, concussions, seizures, headaches, bowel or bladder issues):
- List Chronic Medical Conditions:
- 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).
- Does the participant have a Vision or Hearing Impairment? ☐ No ☐ Yes (If yes, please describe).
- List Surgical History:
- 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: (____) _____