

**NAME:** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_  
                     **Last**                                      **First**                                      **Male:** \_\_\_\_\_ **Female:** \_\_\_\_\_

**Address** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Family Doctor:** \_\_\_\_\_ **Dr's Phone:** \_\_\_\_\_

- CAMPER
- STAFF

**YOUTH CAMP HEALTH EXAM/RECORD  
 FOR CAMPERS AND STAFF**  
 Physical Exams Are Valid For 3 Years  
 From Date of Last Examination

**TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:**

<b>Date of Exam</b> ____/____/____
---------------------------------------

\_\_\_\_\_ May participate in all camp activities  
 \_\_\_\_\_ May participate except for: \_\_\_\_\_  
 \_\_\_\_\_

Medical information pertinent to routine care and emergencies \_\_\_\_\_  
 \_\_\_\_\_

Is this individual taking prescription or over the counter medication(s)? YES  NO  If yes, indicate names of medication(s): \_\_\_\_\_

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

Is the individual on a special diet?  YES  NO Explain: \_\_\_\_\_

Does the individual have special needs?  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, PA, APRN or RN

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

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

# NOTE

Hartford County 4-H Camp authorities reserve the right to reject prospective campers for health reasons. Any person with a known physical defect such as Asthma, Heart Disorder, Diabetes, epilepsy, etc. must have a physical exam before attending and present written doctor's approval to the camp nurse at registration.

The Camp has limited facilities in the infirmary, therefore, campers requiring injections should contact the Director before enrolling.

## **TO PARENTS OF YOUNGSTERS ATTENDING HARTFORD COUNTY 4-H CAMP**

During the camp season, the situation sometimes arises where a camper has to be taken to a hospital for emergency treatment, which means parental consent. In order to facilitate things, please sign the following forms and bring it with you on registration day. Your signature will also signify your approval for the camper to take part in camp hikes, trips, outing, etc.

"In case of emergency, I hereby give my permission to the physicians selected by the Camp Director to hospitalize, to secure treatment for, and to order injections, anesthesia, or surgery for my child as named below."

"I also give permission to the physicians selected by the Camp Director to advise and treat my child for any illness or medical condition while he/she is at camp"

\_\_\_\_\_

CAMPER'S NAME

\_\_\_\_\_

SIGNATURE OF PARENT OR GUARDIAN

Hospital you prefer your camper taken to: \_\_\_\_\_ Town \_\_\_\_\_

Father's Place of business: \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_ Cell \_\_\_\_\_

Mother's Place of business: \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_ Cell \_\_\_\_\_

Person to contact if parents cannot be reached: \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

-----

Any ADA special accommodation must be submitted to the Camp Director, in writing, at least 15 days prior to the start of the camping week, for which the camper is registering.

A copy of a medical form from the child's school, supports activities, Scouting or other youth related organization is acceptable, if it includes all the information and signatures required