



STRATFORD YMCA DAY CAMP

Physical Health Examination to be Completed by a Physician

Please use a separate form for each camper.

Name of camper _____ Date of Birth _____

Date of last physical (must be within 2 years) _____

This examination is for determining fitness and endurance in potentially strenuous activities. All of the information on this form must be completed and may not be substituted by any shorter form.

General Information

Height _____ Weight _____ Blood Pressure _____ Heart _____

Immunization History:

 Please provide confirmation and dates of following immunizations

| | Yes | No | | Yes | No |
|------------|-----|----|-------------|-----|----|
| Measles | | | Hepatitis B | | |
| Mumps | | | Diphtheria | | |
| Rubella | | | Pertussis | | |
| Chickenpox | | | Polio | | |
| Tetanus | | | PCV7 | | |

Medical Conditions

 please check all that apply:

Has the child ever had, or does he/she now suffer from:

Allergy Requiring EPI-Pen ADD/ADHD (explain) _____

Asthma (inhaler Y/N) Autism (explain) _____

Headaches Down Syndrome (explain) _____

Diabetes (insulin pump coverage at camp) Seizures High/ Low Blood Pressure

Cerebral Palsy (explain) _____

Physical Handicaps (explain) _____

Recent or Recovering Fractures Genetic Disorder (explain) _____

Other comments _____

Recommendations

Special Diet: _____ Medication: _____

Other: _____

*** Medication Authorization Form must be sent by physician before nurse can give any medications, including over-the-counter.**

Any Restrictions: Swimming, diving, hiking, climbing, other _____

Physical Authorization

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in an active camp program.

Print name of medical care provider: _____

Print address of medical care provider: _____

Signature of physician, APRN or PA _____ Date _____

Phone _____ Address _____

