HEADS UP! HARTFORD CAMP 2017
CAMP HEALTH EXAM/RECORD FOR STAFF

PHYSICAL EXAMS ARE VALID FOR THREE YEARS FROM DATE OF THE LAST EXAM

Please circle one:

COUNSELOR (FULL-TIME OVERNIGHT) **VOLUNTEER (Staying at least one night)**

NAME_____ D.O.B._____
PHONE_____

ADDRESS_____

EMERGENCY CONTACT_____ PHONE _____

DATE of CAMP_____

To Be Completed by a Medical Professional:

DATE of EXAM ____/_____/____

Please check normal findings:
RESP _____ HEENT _____ CARDIAC _____ NEURO _____ ORTHOPEDIC _____ GLASSES/CONTACTS _____ HEARING AIDS _____

Is the patient being treated currently for any medical conditions? _____

Medications: _____

ALLERGIES: _____Special Diet: _____

Special Needs: _____

Please list any known medical conditions, illnesses, prior injuries or physical restrictions which may limit participation during camp:_____
_____
_____

The counselor/volunteer is up to date on all following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practice: yes ▢ no ▢ EXPLAIN_____
(Attached list of immunizations preferred)

Date of last Tetanus Booster: _____
Print name of Medical care Provider: _____
Address _____ Phone _____

Signature of Physician, PA, APRN or RN _____