

**Camp Eagle Feather**

P.O. 265  
Rocky Hill, CT 06067  
Office: 860 563-2804  
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**YOUTH CAMP HEALTH EXAM/RECORD  
FOR CAMPER AND STAFF**  
Physical Exams Are Valid For 3 Years  
From Date of Last Examination

**Please Return Completed Form to the Camp**

- Camper
- Staff

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_  
Guardian \_\_\_\_\_ Address \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_  
Date of Arrival at Camp: \_\_\_\_\_ Departure Date: \_\_\_\_\_

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

**Date of Exam** \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ 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 \_\_\_\_\_

**Parent signature  
required on back**

\_\_\_\_\_  
Signature of Physician, PA, APRN or RN

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

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

Identify any known medical or emotional illness or disorder that would currently pose a risk to others or which would affect the individual's functional ability to participate safely: \_\_\_\_\_

\_\_\_\_\_

**Parent or Guardian Authorization (Required For All Persons Under Age 18)**

This Health History is correct so far as I know, and the person named on this form has permission to participate in all camp activities except as noted by me or the examining physician. If I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and order injection, anesthesia for surgery for the person named on this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_