

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

**This completed form must be on file before your child can attend 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 medication?  YES  NO  
 If yes, indicate prescription: \_\_\_\_\_

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

Is the individual on a special diet?  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 \_\_\_\_\_

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Signature of Physician, APRN or PA

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Date Form Signed

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Telephone Number