

**HEADS UP! HARTFORD CAMP 2019  
CAMP HEALTH EXAM/RECORD FOR CAMPERS**

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

NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_  
PHONE \_\_\_\_\_

GUARDIAN \_\_\_\_\_  
ADDRESS \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_  
DATE OF CAMP: 6/21/19 - 6/28/19

**To Be Completed by a Medical Professional:**      DATE of EXAM \_\_\_\_/\_\_\_\_/\_\_\_\_

Please check normal findings:  
RESP \_\_\_\_ HEENT \_\_\_\_ CARDIO \_\_\_\_ 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 camper/staff 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 \_\_\_\_\_