



**HEADS UP! HARTFORD CAMP 2020
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: 6/19/20 - 6/26/20

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
