

**HEADS UP! HARTFORD CAMP 2020  
CAMP HEALTH EXAM/RECORD FOR CAMPERS**

Please use this form if your child's school form is unavailable.

**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: 6/19/20 - 6/26/20

**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 \_\_\_\_\_