the YMCA OVERNIGHT CAMP

Health Form – Physician's Exam

Camp Name ☐ Camp Kanata ☐ Camp Sea Gull ☐ Camp Seafarer

Full Name _____

THIS FORM TO BE COMPLETED BY A LICENSED PHYSICIAN

Last Name: _____ **First Name:** _____ **Date of Birth:** ___/___/_____

THE OBJECTIVES OF THIS EXAMINATION ARE TO DETERMINE THAT THIS INDIVIDUAL:

1. Is physically fit to engage in strenuous activities without harm to himself/herself or others.
2. Has no significant infectious condition that could be transmitted to others
3. Has no emotional or physical disorder that could not be cared for under the routine operations and programs of Camp.
   Note: Some special conditions may be handled after individual discussions with Camp.

PHYSICAL

Weight _____ Height _____ B.P. _____/_____

CODE (☐) Normal (X) Abnormal (Explain)

☐ Skin	_____	☐ Nose	_____
☐ Chest	_____	☐ Extremities	_____
☐ Eyes	_____	☐ Throat	_____
☐ Heart	_____	☐ Spine	_____
☐ Ears	_____	☐ Teeth	_____
☐ Abdomen	_____	☐ Neurologic	_____

Menstrual History (if applicable): _____

Recommendations and Restrictions (diet, activity, etc.): _____

_____

Known Allergies: _____

Does this individual have **chronic medical problems, emotional difficulties, eating disorders** or **behavioral** issues of which you are aware? If yes, please describe the condition: ☐Yes ☐No

_____

_____

Does this individual take routine medications or nutritional supplements? *If yes, please list medications or nutritional supplements. Note: A prescription must accompany any medications or supplements listed through camp's contracted pharmacy.* ☐ Yes ☐ No

_____

To coincide with N.C. law for school enrollment, YMCA of the Triangle Overnight Camps REQUIRE THE FOLLOWING IMMUNIZATIONS.

DTaP	**A COPY OF IMMUNIZATION RECORDS SHOULD BE ATTACHED**
Polio (IPV/OPV)	
Hib	
Hepatitis B	
MMR (combined doses)	
Varicella	
Pneumococcal Conjugate	
Meningococcal Conjugate	

Date of most recent PPD (Mantoux) Test ___/___/_____

Test results _____

(If indicated according to AAP recommendations in the Red Book)

Print or Stamp

Physician's Name
Mailing Address
Phone Number

Recommended immunizations received in addition to those above.

Influenza	**IF APPLICABLE, INCLUDE IN ATTACHED IMMUNIZATION RECORDS**
HPV	
Hep A	
BCG/IPPD	

MY SIGNATURE INDICATES I have reviewed the health information above and have examined this patient on _____/_____/_____. [DATE OF EXAM]

Date of Exam (within 12 mos of arrival to Camp)

PHYSICIAN'S SIGNATURE _____ **SIGNATURE DATE** ___/___/___