☐ Camper

☐ Staff

CAMP ASTO WAMAH HEALTH EXAM FORM

Physical Exams are valid for 2 years (24 months) from date of examination

Camper Health Forms should be uploaded to Ultracamp upon completion

Participant Name: _____ DOB: _____

Parent/ Guardian: _____ Phone: _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Date of Exam _____ /_____ /_____

- **Participation– This individual:**
  - □ May participate in all camp activities as outlined on the camp website and brochure (or)
  - □ May participate except for: _____
    _____
- Does the individual have any known medical illness or emotional concerns that pose a risk to other children, or which affects the individual's ability to participate safely in a youth camp?

  □ YES* □ NO If yes, please explain: _____

- **Medication-** Are there any **prescription or over the counter** medication(s) this individual needs to take while at camp? □ YES* □ NO *Total # of medications: _____

  If yes, please list _____

  There is a separate Medication Authorization Form required* ***for each medication* *that will be brought to camp,* ***including over-the-counter medications.***

- **Special Healthcare Needs-** Does this individual have any disabilities or special health care needs such as allergies, epilepsy, Type 1 diabetes, asthma, etc.? □ YES * □ NO

  * If yes, please explain _____

- **Food Allergies/ Dietary Restrictions-** Does the individual have any food allergies or dietary restrictions? □ YES** □ NO If yes, please list/ explain: _____

  _____

** Health care needs that require special care while at camp require an Individual Healthcare Plan (IHP), which will include plan of care, as well as emergency procedures for the camper while they are at camp. This plan will be developed by a Camp Asto Wamah representative with the parent, and updated as needed. This includes life-threatening food and insect allergies, asthma, diabetes, and epilepsy.

- **Immunization–** This participant is up to date on all immunizations as recommended by the State of CT*** □ YES □ NO - Date of last Tetanus shot: _____

  *****Must also have most recent FULL IMMUNIZATION RECORD attached**

- **Additional comments or concerns:** _____
  _____

Printed Name/ Stamp of Physician, PA, or APRN: _____

Address: _____ Phone: _____

Signature of Physician, PA, or APRN: _____ Date: _____