



Connecticut Science Center April Vacation Exploration Camp health exam/record for staff and campers

**Physical Exams Are Valid for 3 years From Date of Last Examination
PLEASE RETURN COMPLETED FROM TO THE CAMP**

Name (please print) _____
First Middle Last

Date of Birth _____
mm/dd/yyyy

Parent/Guardian Name (please print) _____
First Last

Address 1 _____ Address 2 _____

City, State, Zip _____

Home Phone _____ Work _____ Cell _____

Emergency Contact _____ Phone _____

Date of arrival at Camp _____ Date of Departure from Camp _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam: _____ (mm/dd/yyyy)

_____ May participate in all camp activities

_____ May participate except for _____

Medical Information pertinent to routine care and emergencies:

Is this individual taking prescription or over the counter medication(s)? Yes No
 If yes, indicate names of medication(s) _____

Does the individual have allergies? Yes No Explain _____

Is the individual on a special diet? Yes No Explain _____

Does the individual have special needs? Yes No Explain _____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Petussus		
Chicken Pox			Pneumococcal conjugate		
Tetanus			Polio		

Signature of Physician, PA, APRN or RN

Date Form Signed

Telephone Number
