



# Connecticut Science Center Summer 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			Petussis		
Chicken Pox			Pneumococcal conjugate		
Tetanus			Polio		

Signature of Physician, PA, APRN or RN

Date Form Signed

Telephone Number

\_\_\_\_\_

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