

**CONNECTICUT SCIENCE CENTER VACATION SCIENCE EXPLORATION CAMP  
HEALTH EXAM/RECORD FOR STAFF AND CAMPERS  
Physical Exams Are Valid For 3 Years from Date of Last Examination**

**Please Return Completed Form to the Camp**

Staff  
 Camper

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_  
(MM/DD/YYYY)

Parent/Guardian Name \_\_\_\_\_ Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Date of arrival at Camp \_\_\_\_\_ Date of Departure from camp \_\_\_\_\_

**TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:**

**Date of Exam** \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ 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			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Signature of Physician, PA, APRN or RN

\_\_\_\_\_

Date Form Signed

\_\_\_\_\_

Telephone Number