Camp Korp Health Exam/Record for Campers and Staff
Physical exams are valid for 3 Years
from date of last examination

Please Return Completed Form to the Camp

- ○ **Camper**
- ○ **Staff**

Name:_____Date of Birth:___/___/_____ Phone:_____
Parent/Guardian:_____ Address:_____
Emergency Contact:_____Phone:_____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

DATE OF EXAM: ____/____/____

May participate in all camp activities:
○ Yes
○ No
May participate except for:_____

Does the individual have any known illness or disorder that poses a risk to other children or which affects the individual's functional ability to participate safely in a youth camp?
○ Yes
○ No
If yes, please explain:_____

Are there any prescription or over the counter medication(s) this individual needs to take while at camp?
○ Yes
○ No
If yes, indicate name of medication(s):_____
NOTE: A written authorization and parent permission for the administration of medication at camp are required.

Does the individual have any disabilities or special health care needs such as allergies, special dietary needs?
○ Yes
○ No
NOTE: If the camper has a special health care need or disability that requires special care be taken or provided during the time the individual is at camp, an individual plan of care shall be developed with the parent and health care provider and updated as necessary. The plan shall include appropriate care of the camper in the event of a medical or other emergency and signed by the parent and staff responsible for the care of the camper.

If camper/staff is school aged or younger, have they been immunized in accordance with the schedule adopted by the Commissioner of Public Health pursuant to section 19a-7f of the CT General Statutes?
○ Yes
○ No

Printed Name of Healthcare Provider:_____
Address:_____ **Phone:**_____
Signature of Physician, PA, APRN or RN: _____ **Date signed:**_____