

**Regional YMCA of Western Connecticut
2 Huckleberry Hill Road
Brookfield, CT 06804**

**Attn: Allison Coleman/ Basketball Camp
Phone: (203) 775-4444
Fax: (203) 740-9289**

Campers NAME _____

Date of Birth _____ Home Phone _____ Cell Phone _____

Address _____

**TO BE COMPLETED BY A MEDICAL PRACTITIONER:
A physician must have completed a physical examination within the last 36 months.**

_____ May participate in all camp activities

Date of Exam _____

_____ May participate except for: _____

Medical information pertinent to routine care and emergencies: _____

Is this individual taking prescription medication? YES NO

If yes, indicate prescription: _____

Does the individual have allergies? YES NO Explain: _____

Is the individual on a special diet? 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			Polio		
Tetanus					

Comments: _____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care providers: City/Town _____ ST _____ Zip Code _____

Signature of Physician, APRN or PA

Date Form Signed

Telephone Number