Regional YMCA of Western Connecticut
YMCA Camp Greenknoll

YOUTH CAMP HEALTH EXAM/RECORD

Fax
Before 6/20 - (203) 740-9289
After 6/21 - (203) 740-3639

☐ CAMPERS
☐ STAFF

Last Name: _____ First Name: _____ Date of Birth: ____/____/____

Address: _____

Parent/Guardian: _____ Phone_____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Date of Physical Exam _____/_____/_____
Physical exams are valid for 36 months from the date listed.

May participate in all camp activities ☐ YES ☐ NO

May participate except for: _____

Does the individual have any disabilities or special health care needs such as allergies, special dietary needs? ☐ YES ☐ NO If yes, please explain:

_____

_____

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.

Are there any prescription or over the counter medication(s) this individual needs to take while at camp?
☐ YES ☐ NO If yes, indicate names of medication(s):

_____

NOTE: ANY MEDICATIONS (prescription or OTC) THAT ARE TO BE ADMINISTERED AT CAMP MUST BE ACCOMPANIED BY AN AUTHORIZATION FOR THE ADMININSATRATION OF MEDICATION FORM COMPLETED AND SIGNED BY A PHYSICIAN AND A PARENT/GUARDIAN.
***Authorization for the Administration of Medication from can be found at **regionalymca.org**

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 Connecticut General Statutes. *If applicable this form must be accompanied by immunization records.*

Additional Comments:

_____

_____

Printed Name of Health Care Provider: _____

Address: _____ Phone: _____

Signature of Physician, PA, APRN or RN _____ Date Form Signed: _____