CHOP POINT HEALTH EXAM/RECORD FOR CAMPERS

Physical Exams Are Valid If Preformed Within 2 Years of June 20th of the Current Camp Year.

Please Return Completed Form to camp@choppoint.org
or upload it into your CampDoc profile.

Name _____ Date of Birth _____ Phone _____

Guardian _____ Address _____

Emergency Contact _____ Telephone _____

Date of Arrival at Camp: _____ Departure Date: _____

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 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		

Comments:_____

_____

_____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town _____ST _____ Zip Code _____

_____

Signature of Physician, PA, OR APRN

_____

Date Form Signed

_____

Telephone Number