YMCA of the Triangle Overnight Camp

Camper Physical

☐ Camp Kanata
☐ Camp Sea Gull
☐ Camp Seafarer

Full Name: _____

THIS FORM IS TO BE COMPLETED BY A LICENSED PHYSICIAN

THE OBJECTIVES OF THIS EXAMINATION ARE TO DETERMINE THAT THIS INDIVIDUAL:

1. Is physically fit to engage in strenuous activities without harm to himself/herself or others.
2. Has no significant infectious condition that could be transmitted to others.
3. Has no emotional or physical disorder that could not be cared for under the routine operations and programs of Camp.
   Note: Some special conditions may be handled after individual discussions with Camp.

LAST NAME: _____ **FIRST NAME:** _____ **DOB:** ___ / ___ / _____ (MM / DD / YYYY)

DATE OF EXAM: ___ / ___ / _____ **Weight** _____ **Height** _____ **B.P.** _____ /_____

CODE (☐) Normal (X) Abnormal (explain)

☐ Skin	_____	☐ Nose	_____
☐ Chest	_____	☐ Extremities	_____
☐ Eyes	_____	☐ Throat	_____
☐ Heart	_____	☐ Spine	_____
☐ Ears	_____	☐ Teeth	_____
☐ Abdomen	_____	☐ Neurologic	_____

Menstrual History (if applicable)**:** _____

Recommendations and Restrictions (diet, activity, etc.): _____

_____

Known Allergies: _____

Does this individual have **chronic medical problems, emotional difficulties, eating disorders** or **behavioral issues** of which you are aware? If yes, please describe the condition: ☐ Yes ☐ No

_____

_____

Does this individual take **routine medications** or **nutritional supplements**? If yes, please list medications or nutritional supplements. Note: A prescription must accompany any medications or supplements listed through Camp's contracted pharmacy. ☐ Yes ☐ No

_____

To coincide with the N.C. law for school enrollment, YMCA of the Triangle Overnight Camps **REQUIRE THE FOLLOWING IMMUNIZATIONS:**

DTaP	**A COPY OF IMMUNIZATION RECORDS SHOULD BE ATTACHED**
dT/TdaP	
Polio (IPV/OPV)	
Hib	
Hepatitis B	
MMR (combined doses)	
Varicella	
Pneumococcal Conjugate	
Meningococcal Conjugate	

Date of most recent **PPD (Mantoux) Test**: ____ / ____ / _____

Test results: _____

If indicated according to AAP recommendations in the Red Book)

RECOMMENDED IMMUNIZATIONS in addition to those listed as required.

Influenza	**IF APPLICABLE, INCLUDE IN ATTACHED IMMUNIZATION RECORDS**
HPV	
Hep A	
BCG/IPPD	
COVID-19	

PRINT OR STAMP

PHYSICIAN'S NAME, ADDRESS, PHONE NUMBER

MY SIGNATURE INDICATES I have examined this patient, reviewed the health history and am attaching immunization records.

PHYSICIAN'S SIGNATURE _____ **SIGNATURE DATE** ____ / ____ / ____