

Maine Youth Fish & Game Association
Camp Health Examination Form

Camper Information

| | | | |
|-----------------|-------|------|-------|
| Name: | _____ | DOB: | _____ |
| Gender: M / F | _____ | Age: | _____ |
| Parent/Guardian | _____ | | _____ |
| Name(s): | _____ | | |

Physician Examination Requirement

A physical examination by a licensed physician is required **within two years** of camp start date. Parents/guardians please include any recent changes to health history or medications.

Physician's Assessment (page 1 of 2)

Immunization History

Is the camper up to date on immunizations? **YES / NO (circle one)**

Complete the following or attach a record of these immunizations.

| Vaccine | Date of Basic Immunization | Date of Last Booster |
|----------------------------------|----------------------------|----------------------|
| DTaP | | |
| Oral Polio | | |
| MMR | | |
| Varicella | | |
| Tetanus | | |
| Hepatitis Series 1 st | | |
| 2 nd | | |
| 3 rd | | |

Health History (Check Yes or No)

| | Yes | No | | Yes | No |
|-------------------------|-----|----|---------------|-----|----|
| Frequent ear infections | | | Mononucleosis | | |
| Heart defect / disease | | | Chicken Pox | | |
| Seizures/epilepsy | | | Measles | | |
| Diabetes | | | Hepatitis | | |
| Bleeding/Clotting | | | Mumps | | |
| Hypertension | | | Asthma | | |
| Epilepsy | | | | | |

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Allergies? (Latex, foods, medication, etc.) _____

Surgeries or serious injuries? (Dates) _____

Disability or chronic recurring illness? _____

Explain any reported loss of consciousness, convulsion, or concussion if different from above: _____

Current medications:

Any side effects or medication-based reactions the camp should be aware of?

Note medications that will need to be administered at camp: (name, dosage, time, etc.)

| | |
|--|--|
| | |
| | |

Any medically prescribed dietary restrictions? _____

Other health concerns or restrictions?

Physician's Statement of Fitness

This camper will be participating in physical activities such as boating, hiking, and outdoor recreation.

This camper is under care for the following conditions: _____

In my professional opinion, the camper's condition:

DOES / DOES NOT (circle one) preclude participation in a reasonably active camp program.

Date of last physical examination: _____

****Licensed Physician's Signature:** _____

Physician's printed name: _____

Contact Phone #: _____

Date: _____

Please return this form to the camper's parent/guardian