Camp River Run
HEALTH EXAM/RECORD

Please Return Completed Form to Camp River Run by the date of participation

☐Camper ☐Staff/Volunteer

Name _____ Date of Birth _____ Guardian _____

Emergency Contact _____ Telephone _____

Dates of Camp River Run Participation: _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam _____/____/_____

May participate in all camp activities ☒ Yes ☐No

Except for: _____

Medical information pertinent to routine care and emergencies: _____

_____

Is this individual taking prescription or over the counter medication(s)? ☐ Yes ☐ No

Medication, Route, Dosage (include any emergency medication) are any new in the last 6 months?

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/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			Pneumococcal conjugate		
Tetanus			Polio		

Comments: _____

_____

_____

Print name of medical care provider: _____

Signature of Physician, PA, APRN or RN _____

Date Form Signed ____/____/_____ Telephone Number_____

Updated 6/2018