New Canaan Recreation Department
YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS AND STAFF
Physical Exams Are Valid for 3 Years From Date of Last Examination

Please Return Completed Form to: New Canaan Recreation Department
P.O. Box 852 New Canaan, CT 06840
FAX:  203-594-3606

___CAMPER
___STAFF

Name__________________________________Birthdate___/___/____  Home Phone_______________
Guardian____________________________ Address________________________________________
Camp:____Waveny Camp           ____Pee Wee Camp           ____Tiny Tot Camp
Session(s):  ____I      ____II      ____III

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Physical 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/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:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Measles</td>
<td></td>
<td>Hepatitis B</td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td>Diphtheria</td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td>Pertussis</td>
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<tr>
<td>Chickenpox</td>
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<td>Polio</td>
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<tr>
<td>Tetanus</td>
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Comments:_________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Print name of medical care provider:_________________________________________________________________________

Medical care provider’s address:_________________________________________________________________________

Medical care provider’s:  City/Town________________________________________ST____Zip Code_______________

Signature of Physician, APRN or PA

Date Formed Signed

Telephone Number