PFFWCF Alliance for Fire Safety "Burn Camp"

Camper Health Exam/Record **Please be advised this is for the child to attend a camp for burn-injured youth**

TO BE COMPLETED BY PHYSICIAN/QUALIFIED HEALTH PROFESSIONAL

(Qualified health professional includes MD, DO, NP, PA)

Camper Name:	Date of Birth:	
Date of Exam:	Height:	Weight:

CAMPER IMMUNIZATIONS:

Please provide dates of immunizations:

- ☐ Varicella _____
- ☐ Measles _____
- ☐ Mumps _____
- ☐ Rubella _____
- ☐ Tetanus _____
- ☐ Hepatitis B _____
- ☐ Diphtheria _____
- ☐ Pertussis _____
- ☐ Polio _____

If immunizations are not up to date, please explain why:

CURRENT MEDICATIONS

Is camper currently taking any medications? *(please include over the counter medications)*

- ☐ YES **Camper MUST bring medications in original containers to camp.**
- ☐ NO

If yes, please list medications below: *(if necessary, please attach list of current medications)*

Name of Medication	Date Started	Reason for medication	When/Frequency	Amount/Dose

ALLERGIES

This camper is allergic to: ☐ No known allergies

☐ Food ☐ Medicine ☐ The environment (insect sting, hay fever, etc) ☐ Other

Please describe below what the camper is allergic to and the reaction seen:

RESTRICTIONS

Does this camper have any medically related restrictions that will limit him/her from participating in activities?

☐ YES ☐ NO

If yes, please explain:

CONTACT INFORMATION (for Health Provider completing this form)

Print Name:	Phone Number:
Provider Address, City, State, Zip:	_____ **Signature (with credentials)** **Date**

THIS FORM MUST BE PRINTED AND FILLED OUT BY HAND