Camper Last Name:

PFFWCF Summer Camp for Burn Injured Youth
2021 Camper Health Exam/Record

FORM TO BE COMPLETED BY PHYSICIAN/QUALIFIED HEALTH PROFESSIONAL (MD, DO, NP, PA)

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

CAMPER IMMUNIZATIONS:

Please provide dates of immunizations (or attach record to this form)

- ☐ Varicella____________________
- ☐ Measles____________________
- ☐ Mumps____________________
- ☐ Rubella______________________
- ☐ Tetanus______________________
- ☐ Hepatitis B___________________
- ☐ Diphtheria ___________________
- ☐ Pertussis ___________________
- ☐ Polio _______________________
- ☐ COVID-19__________________

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

Camper is allergic to: ☐ No known allergies

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

Please describe below the camper allergy and the reaction:

PMH (Past Medical History)

Camper Last Name:

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*****