PFFWCF Summer Camp for Burn Injured Youth
2024 Camper Health Exam/Record

FORM TO BE COMPLETED BY 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 or attach list of current medications

Name of Medication	Dose	FREQUENCY	INDICATION

ALLERGIES

Camper is allergic to: ☐ No known allergies

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

Please list allergy and reaction below:

PMH (Past Medical History)

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**