PFFWCF Summer Camp for Burn Injured Youth

2025 Camper Health Exam/Record

FORM MUST BE COMPLETED BY A QUALIFIED HEALTH PROFESSIONAL (MD, DO, NP, PA)

Camper Information

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

Immunizations

Please provide dates of immunizations or attach a record. If not up to date, explain why and provide a plan of care.

Varicella		Rubella		Diphtheria	
Measles		Tetanus		Pertussis	
Mumps		Hepatitis B		Polio	
COVID-19					

Current Medications (REQUIRED)

Is the camper currently taking any medications (prescription, OTC, or supplements)? Providers must list each medication with dose, frequency, route, and indication (or attach a current medication list).

[ ] Camper does not take any medication currently

Medication	Dose	Frequency	Route	Indication	Should be taken at camp? Yes/No August 10 – 16, 2025
					[ ] Yes [ ] No
					[ ] Yes [ ] No
					[ ] Yes [ ] No
					[ ] Yes [ ] No

Allergies

Please check all that apply and describe the reaction. Include severity and if camper carries an EpiPen.

[ ] No known allergies	[ ] Food	[ ] Medicine	[ ] Environmental	[ ] Other
Please list allergens, reaction & severity:				

Past Medical History (PMH):

_____

Restrictions

Does this camper have any medically related restrictions that will limit participation in camp activities?
[ ] Yes [ ] No

If yes, please list restrictions:

_____

Health Provider Information and Signature

I affirm that the above medications and medical information are complete and accurate to the best of my knowledge. Please NOTE** Incomplete forms may delay camper participation.

Provider Name (please print)		Phone Number:	
Address:		Fax Number:	
Signature (with credentials):		Date:	