



# CAMP COCHIPIANEE

SUMMER DAY CAMP 2021  
YOUTH CAMP HEALTH EXAM/RECORD



**PLEASE RETURN COMPLETED FORM TO CAMP COCH**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Guardian: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### Emergency Medical Consent

I accept complete responsibility for the health of the Participant and will not allow him/her to participate in the activity above unless, to the best of my knowledge, he/she is in good health. In case of medical emergency, I give permission to the Town of Goshen Recreation Department and its agents and employees to seek proper medical treatment, including hospitalization, and to authorize injection, anesthesia or surgery for the Participant if deemed necessary by a licensed or certified healthcare provider.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent/Guardian)

### **BELOW TO BE COMPLETED BY SPECIFIED MEDICAL PRACTITIONER:**

**DATE OF 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 medications: \_\_\_\_\_

- Does the camper have **allergies**?  YES  NO **Epipen?**  YES  NO
  - If yes, specify: \_\_\_\_\_
- Is the camper on a **special diet**?  YES  NO
  - If yes, specify: \_\_\_\_\_

This camper is up-to-date on all the following routine childhood immunizations currently recommend by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	YES	NO		YES	NO
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Comments: \_\_\_\_\_

Print Name of Medical Care Provider: \_\_\_\_\_

Medical Care Provider's Phone #: \_\_\_\_\_

Medical Care Provider's City/Town, State: \_\_\_\_\_, \_\_\_\_\_

Signature of Physician, PA, APRN or RN: \_\_\_\_\_

Date Form Signed: \_\_\_\_\_