CAMP COCHIPIANEE

SUMMER DAY CAMP 2024

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: ____/____/_____(must have been completed after August 9, 2021)

___ May participate in all Camp activities.

___ May participate except for: _____

Medical information pertinent to routine care and emergencies: _____

- 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: _____