

Session: \_\_\_\_\_  
Session Dates: \_\_\_\_\_  
Fax: 612-465-0559  
Phone: 612-822-2267



YMCA Camp Warren  
HEALTH EXAM FORM  
Summer 2010

**Return to:**  
YMCA Camp Warren  
2125 E. Hennepin Avenue  
Suite 100  
Minneapolis, MN 55413-1763  
Fax: 612-465-0559

**Parents: Have your Physician or Nurse Practitioner complete this form each year.**

The information can be based on an examination done within the past two years (24 months from the start of the session).

**Camper's Name:** \_\_\_\_\_ **Date of Medical Evaluation:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_

In my opinion, this person's condition **does does not** allow his/her participation in an active camp program.

Please describe any restrictions for participation: \_\_\_\_\_

Current treatment to be continued at camp (include current medications): \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion, or concussion: \_\_\_\_\_

This person is allergic to the following (food, medication, etc.): \_\_\_\_\_

Treatment for allergic response: \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions: \_\_\_\_\_

Any specific safety considerations (no top bunk, lifejacket required while swimming, weight camper can carry, necessary medications, etc): \_\_\_\_\_

Does this person have epilepsy?      \_\_\_ Yes      \_\_\_ No  
    Is this condition able to be controlled by camper?      \_\_\_ Yes      \_\_\_ No  
Does this person have diabetes?      \_\_\_ Yes      \_\_\_ No  
    Is this condition able to be controlled by camper?      \_\_\_ Yes      \_\_\_ No  
Does this person have asthma?      \_\_\_ Yes      \_\_\_ No  
    Is this condition able to be controlled by camper?      \_\_\_ Yes      \_\_\_ No

**Immunization History:** Provide the month and year for each immunization or send print-out from Physician's office.

\_\_\_\_\_ Tetanus Booster      \_\_\_\_\_ Hepatitis B  
\_\_\_\_\_ Chicken Pox      \_\_\_\_\_ MMR

**Additional Parental or Doctor Notes:** Include any other medical information that will assist us in making camp a positive experience. Attach additional paper if needed. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physician or Nurse Practitioner Signature:** \_\_\_\_\_

**Clinic Name:** \_\_\_\_\_ **Office Phone:** \_\_\_\_\_

**Clinic Address:** \_\_\_\_\_

**Date of Form Completion:** \_\_\_\_\_