CONNECTICUT BASKETBALL SCHOOL

YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF

Physical Exams Are Valid For 3 Years
From Date of Last Examination

☐ Camper
☐ Staff

Please Return Completed Form to Camp

Name_____ Date of Birth_____ Phone_____

Guardian_____ Address_____

Emergency Contact_____ Telephone_____

Date of Arrival at Camp:_____ Departure Date:_____

TO BE COMPLETED BY THE 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 medication? ☐ YES ☐ NO
If yes, indicate prescription:_____

Does the individual have allergies? ☐ YES ☐ NO Explain:_____

Is the individual on a special diet? ☐ YES ☐ NO Explain:_____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended 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			Polio		
Tetanus					

Parent or Guardian Authorization (required for all persons under age 18)
This Health History is correct so far as I know and the person named above has permission to participate in ALL camp ac
except as noted by me or the examing physician. If I cannot be reached in an emergency, I hereby authorize the physican
by the camp to hospitalize, secure proper treatment for and order injection, anesthesia for surgery for the person name abo
Parent or Guardian (Signature):_____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town_____ST_____Zip Code_____

_____
Signature of Physician, APRN or PA

_____
Date Form Signed

_____
Telephone Number