Camp Session _____ **HARTFORD COUNTY 4-H CAMP, INC.**

HEALTH ASSESMENT RECORD

Physical Exams are VALID for 3 years from date of last examination

Camper/CounselorName_____Birthdate_____Gender M F

Address_____

Parent/Guardian Name*_____Best Phone #_____

To Be Completed by the Specified Medical Practitioner **Date of Exam_____**

Chronic Disease Assessment-please circle

Y N **Asthma** Intermittent Mild Persistent Severe Persistent Exercise Induced

** Parent/Guardian-**If YES** please provide a copy of the **ASTHMA ACTION CARE PLAN** to the Camp Nurse*

Y N **Anaphylaxis** Food Insects Latex Nuts Unknown Source

Y N **Allergies** History of Anaphylaxis Epi Pen Required **Y N**

Parent/Guardian-If YES** please provide a copy of the **EMERGENCY ALLERGY CARE** PLAN to the Camp Nurse*

Y N **Diabetes** Type 1 Type 2

Y N **Seizures Disorder** type_____

Y N This Individual has the following problems which may affect His or Her Camp experience

Vision Auditory Speech/Language Developmental Physical Emotional Behavioral /Psychiatric

Explain_____

Y N Taking Prescription and/or OTC medications- **If YES** an **Authorization to Administer Medication** form must be completed and signed by Medical Practitioner and presented to Camp Nurse upon arrival.

_____May Participate in all Activities

_____May Participate in All Activities Except for_____

Medical information pertinent to routine care and emergencies: _____

_____**Parent/Guardian-**If YES** please provide a copy of the **EMERGENCY PLAN OF CARE** to the Camp Nurse*

Y N **Immunization Up To Date** **Must Have Immunizations Record below or on a Separate Form**

Immunization Record	Dose 1 M/D/YR	Dose 2 M/D/YR	Dose 3 M/D/YR	Dose 4 M/D/YR
DTP/DTaP				
OPV				
MMR				
Hepatitis A				PK & K born 1/2007 or later
Hepatitis B				
Varicella				
PCV				PK & K born 1/2007 or later
Meningococcal				Required for 7th grade
Tetanus				

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:

Y N **Based on a comprehensive health history and physical examination this camper has maintained His or Her level of wellness**

_____ _____

Printed Name of Medical Provider Medical Provider Address and Phone

X_____

Signature of MD,PA,APRN,RN designee Date Signed