

Session: _____
Session Dates: _____



Fax: 612-465-0559
Phone: 612-822-2267

YMCA Camp Ihduhapi
HEALTH EXAM FORM
Summer 2010

Return to:
YMCA Camp Ihduhapi
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: _____