VHP-A HINDU HERITAGE YOUTH CAMP
HEALTH EXAM FOR CAMPERS

Name:_____ Date of Birth:_____Home Phone:_____

Address:_____City:_____State:_____Zip:_____

Parent/Guardian 1 Name:_____

Parent/Guardian 1 Home Number:_____Work Number: _____ Cell Number:_____

Parent/Guardian 2 Name:_____

Parent/Guardian 2 Home Number:_____Work Number: _____ Cell Number:_____

Emergency Contact Name :_____Contact Number:_____

NOTICE: CAMPERS AND STAFF MUST PROVIDE COPY OF UPDATED IMMUNIZATION RECORD

TO BE COMPLETED BY MEDICAL PRACTITIONER

Date of Exam:_____

_____May participate in all camp activities

_____May participate except for:_____

_____

Is this individual taking prescription medication? ___YES ___NO

If yes, please specify:_____

Does this individual have allergies? ___YES ___NO

If yes, please specify:_____

Is this individual on a special diet? ___YES ___NO

If yes, please specify:_____

Is this individual up-to-date on immunization? ___YES ___NO

If yes, please specify:_____

Signature of Physician: Date:

_____ _____

Printed name of Physician: Phone Number of Physician:

_____ _____

Address of Physician:

Address_____City_____State_____Zip_____