



# CAMP COCHIPLANE

SUMMER DAY CAMP 2025

YOUTH CAMP HEALTH EXAM/RECORD



**PLEASE RETURN COMPLETED FORM TO CAMP COCH**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Guardian: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Emergency Medical Consent

I accept complete responsibility for the health of the Participant and will not allow him/her to participate in the activity above unless, to the best of my knowledge, he/she is in good health. In case of medical emergency, I give permission to the Town of Goshen Recreation Department and its agents and employees to seek proper medical treatment, including hospitalization, and to authorize injection, anesthesia or surgery for the Participant if deemed necessary by a licensed or certified healthcare provider.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent/Guardian)

## **BELOW TO BE COMPLETED BY SPECIFIED MEDICAL PRACTITIONER:**

**DATE OF EXAM: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (must have been completed after August 3, 2021)**

\_\_\_\_ May participate in all Camp activities.

\_\_\_\_ May participate except for: \_\_\_\_\_

Medical information pertinent to routine care and emergencies: \_\_\_\_\_

- Does the patient have **allergies**? ☐ YES ☐ NO **Epipen?** ☐ YES ☐ NO
  - If yes, specify: \_\_\_\_\_
- Is the patient on a **special diet**? ☐ YES ☐ NO
  - If yes, specify: \_\_\_\_\_

This patient is up-to-date on all the following routine childhood immunizations currently recommend 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 |     |    | Pneumococcal conjugate |     |    |
| Tetanus    |     |    | Polio                  |     |    |

Comments: \_\_\_\_\_

Print Name of Medical Care Provider: \_\_\_\_\_

Medical Care Provider's Phone #: \_\_\_\_\_

Medical Care Provider's City/Town, State: \_\_\_\_\_, \_\_\_\_\_

Signature of Physician, PA, APRN or RN: \_\_\_\_\_

Date Form Signed: \_\_\_\_\_